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ORIGINAL ARTICLES.

A CASE OF "LUPUS" SUCCESSFULLY TREATED BY AN IODINE COMPOUND.

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Nearly every practitioner will come to stasis during the treatment of some rebellious affection, and if not favored by a condition of spontaneous leniency on the part of nature, he is apt to merge into a misty atmosphere of scientifically applied medicine; in which the word scientific apparently becomes obscure. Happily, by undaunted persistence, we were, in this case, saved the acknowledgment of the above state, and recompensed by the condition of success.

The recent history of this case—the part most interesting—dates from September, 1894. The condition of ulcer at that time was deep, its base presenting a series of vesicular granules which were large and easily destroyed. Studded here and there through these could be seen a white fibrous film, which, if left to itself, would coalesce into nodules, which were hard and very painful. These, in turn, would break down and discharge upon the surface. The edges were irregular and dense, so much so as while cutting through them no bleeding was produced. This cutting was difficult and attended with a great amount of pain. The general appearance was convincing of its indurated indolent condition.

Dr. Rainear and myself agreed that it was advisable to excise all tissue in and around the ulcer, so as to place us upon a healthy basis for treatment. This was done. The resultant wound was dressed like any surgical wound, using a dusting-powder composed of aristol and boric acid. After several of these dressings, there was a notable improvement, with a marked tendency for the wound to fill and contract. This gave evidence that we were working in the right direction.

When the healing was nearly completed, there appeared on the surface of this newly-formed tissue a small papule, raised, firm and painful to the touch. In the course of three or four days this

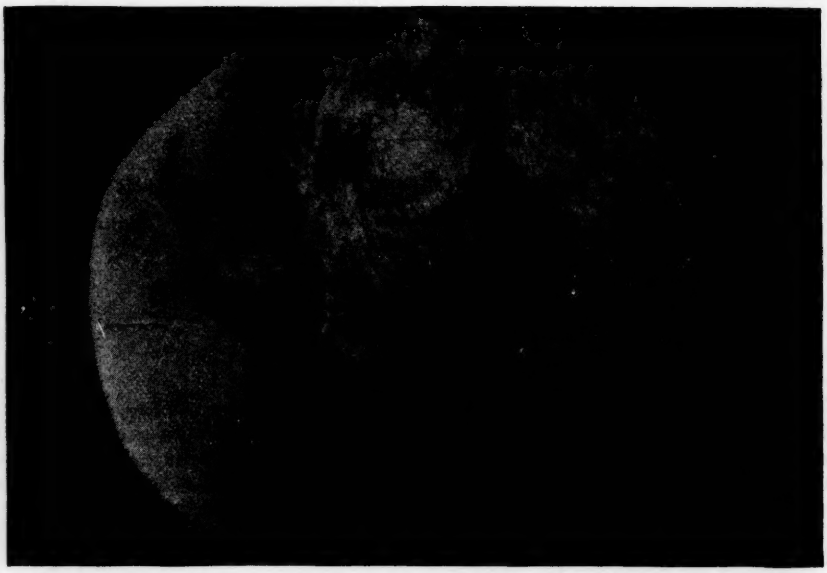
papule gave way to a small depression, which, on being opened, was found to contain a fluid substance of a thin, sanguineous nature. At the bottom of this small, newly-formed cavity (made by the opening) could be seen a white substance, which was hard, and when not excised would soften, burrow its way under the surrounding tissue and undermine it.

These little papules occurred so often during the process of healing that the patient sought for their immediate removal so soon as they were discovered, fearing, as he expressed, that they would form cellars, which would necessitate opening the entire area and cleaning away all of the white material present. We were required to repeat this process over some thirty times, carefully cauterizing the remaining surface, the patient having a standing dread that this would occur at each visit.

From the period of excision in 1894 to August, 1896, we have tried and used different remedies from those which are known as infallible specifics to the most humble, namely, moist gauze, but without results.

During this Fall, the powder which I was using became exhausted. As the wound was foul and discharging freely, it occurred to me to try iodine. A small pad of absorbent cotton was dipped in a diluted iodine solution and packed in the wound. This mode of dressing was continued, making at each time the solution stronger until the discharge had entirely ceased. After paring away the dead and stained tissue, the surface of the wound presented evidence of active inflammation. The granulations were of a bright, healthy type.

I had a package of an iodine compound left at my office. It was in the form of a powder called antinosine.



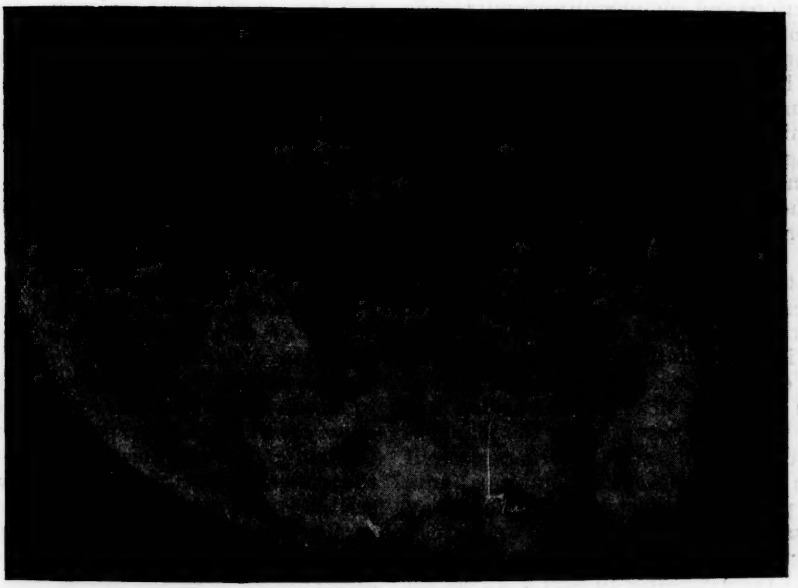
This was used instead of the wet dressing, at first in its full strength, which caused the wound to discharge most freely, making it necessary to change the dressing twice a day. After a few weeks of the use of this remedy, and trimming the edges from time to time, thus the callous indolent sore of over three years' standing became gradually transformed into one of a clean nature. The powder was changed to one composed of bismuth subnitrate, twenty parts; antinosine, one part. This combination was maintained in use until healing was complete, which was gradual and uninterrupted. The above cut will

show the resultant scar which represents two-thirds of its natural size.

So much for the present, and now let us refer to his past, which is:

G. H., white, male, aged thirty-two years, born in this country. Parents and two brothers which comprise the family are living and well. Their history does not reveal that in them any constitutional diseases ever existed. His early childhood was a life of continued illness before the age of seven, being subjected to measles and scarlet fever. At about twelve he had a severe attack of intermittent fever, which terminated into one of typhoid. From very slow recovery a most distressing condition ensued, namely, looseness of bowels, occurring at intervals, and lasting nearly sixteen years. These attacks were diagnosed as dyspeptic, the patient at that time being most indiscreet in relation to his diet. These were finally checked after the most rigid treatment.

Some four years ago, on the skin of the forehead, there appeared a small pimple which sloughed, quickly spread, and became about the size of a half dollar. At the same time similar sores were found to exist upon the leg and arm. They were cutaneous, and treated like any ordinary sore. Those of the forehead and arm healed rapidly, while that of the leg required the aid of the curette and subsequent packing to effect a cure. In a brief space of time another sore, beginning of a similar character, made its entry on the lower surface of the left arm, just above the olecranon. This is the above ulcer; and that which I wish to bring to your notice is the difference between it and the others in the respect of duration in the time of healing, the tendency to the formation of these nodules, and its offering such repellent condition to the action of most drugs. I mention nothing about the microscopic examination of this white material, nor of the sanguineous fluid that came from the breaking down of the papules for the simple reason that they did not reveal anything of interest except the diagnosis.



Waddington: I notice you don't talk much when you dine out. "No, it takes all the brains I can muster to work things so I won't come out with an oyster fork for my after-dinner coffee." —*Chicago Record.*

A SERIES OF DIET TABLES ADAPTED TO VARIOUS DISEASES AND SYMPATHETIC DISTURBANCES OF THE STOMACH AND INTESTINES AS WELL AS TO CERTAIN OTHER DEVIATIONS FROM HEALTH.

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A prominent German author recently wrote a work on diseases of the stomach and bowels, dividing it into two volumes.* The first volume is devoted entirely to the dietetic treatment of such affections and includes an appendix made up of culinary recipes. Of the second volume the first part embracing nearly one half of the book is occupied with a consideration of the physical or mechanical methods of treatment such as lavage, irrigation of the bowels, nutrient enemata, massage, electrical applications to the stomach and intestines, baths or other applications of water externally and finally orthopedic treatment and curative gymnastics. Last of all there appear some chapters on the medicinal treatment of the diseases in question. Yet in this country a physician runs the risk of being considered eccentric if he does not make drug treatment his first and principal resource in the management of the digestive disorders as well as in all other diseases. Many patients will plainly manifest surprise, not to say disgust, upon being asked to restrict their diet, evidently believing that it ought to be possible to find a physician who could cure them radically by drugs alone, allowing them to go on meanwhile eating and drinking the same things that brought their disease upon them. But a very little reflection should convince them that this is a serious mistake.

When there is acute general disease as in fever, the whole body is rested by the patient being put to bed. When an arm or leg is broken, complete rest of the affected part is secured by putting it into a splint. When the stomach is seriously damaged either by injury or disease, it also imperatively requires rest in order to regain its normal condition; but, it is impossible to give it absolute rest and yet maintain life for any length of time. Fasting is usually safe for a few days but rarely longer in the case of invalids. Rectal feeding may often be depended on for a longer period—about four weeks. After that in even the worst cases food must again be given via the stomach. Partial rest, then, is all we are able to give the digestive system. Some portion of it must be kept at work, even when sick.

Hence the difficulties attendant upon the treatment of the chronically diseased digestive organs. Even though crippled they cannot have the rest which would allow them to recover speedily. But by means of diet we can do much in the direction of resting them. When the disease is found by the appropriate tests to involve the stomach exclusively or chiefly, while the liver, pancreas and intestinal glands are normal, we can spare the suffering part very much by prescribing food which is digested mainly in the intestines and by insisting upon thorough mastication, so as to get all the help possible from the saliva.

When, on the other hand the stomach is shown to be comparatively healthy and the other parts of the digestive apparatus are at fault, we reverse the process, and give foods which can be digested mainly in the stomach.

When all these parts are involved, as is too often the case, we may still afford partial rest by so controlling the diet as to exclude the most fermentable articles and prevent overburdening of the afflicted organs from an excess of even proper food, or by food which is either naturally tough and indigestible or made so by bad cooking.

Thus it may be seen how important, how indispensable, indeed, it is, if cura-

*Die diaetetische Behandlung d. Magen-Darmerkrankungen; and Die physikalische und medicamentoese Behandlung d. Magen-Darmerkrankungen von Dr. Carl Wegele, Jena. 1893 and 1895.

tive results are to be obtained, to have cases of indigestion systematically examined by the exact methods now at our command, and the diet carefully adapted to them.

Nor can this adaptation be done once for all. Every case must be studied and the results of the diet and treatment on the urine, feces, blood, body weight, nerve state, etc. closely watched. But with the earnest and conscientious cooperation of the patient and the patient's friends with the efforts of the physician, very much can be accomplished.

The following general hygienic hints should save patients from many mistakes and relapses:

Persons having a delicate digestion should never eat a hearty meal when very tired, vexed, worried or cold. If they have been exercising severely, they should lie down or rest in some easy position for half an hour before eating. They should eat slowly and simply, combining few things in one meal. They should also endeavor so far as possible to dine in pleasant company and to cultivate a cheerful spirit at the meal hours. It is not well for them to exercise either the mind or body actively for at least half an hour, and better, an hour, after their principal meals, especially after their dinners. They must learn to use their saliva for the purpose of moistening and partly digesting their farinaceous food instead of washing it down with drinks. Let them keep their feet warm, their heads cool, their kidneys active and their bowels open, by simple natural methods, such as exercise, drinking freely of water between meals, etc., avoiding drugs for these purposes except when especially ordered by their physician.

These diet tables are intended for use under the personal advice and direction of the physician. Some one of the first three or four will usually agree best in the beginning of the treatment, the more liberal ones being allowed later as the case improves. But the results observed may necessitate going back at times to a more stringent list temporarily; and in certain cases the best results may be obtained by combining some of the features of two or more of the diet tables. But, naturally, the most perfect diet rules possible will do no good unless strictly followed.

Diet Table No. 1.

Take every two hours from a wineglassful to a gobletful of peptonized milk, matzoon or whey; or a teacupful of clam broth, chicken broth, beef tea or any meat broth slightly seasoned and with the fat all skimmed off; or the same quantity of rice water, barley water, toast water, gum arabic water or egg water may be given as an alterative nutriment. When there is obstinate vomiting, a tablespoonful of any of the above may be given every fifteen minutes till the stomach has been settled.

Diet Table No. 2.

Take every two hours the juice from a quarter to a half-pound of lightly broiled lean beef expressed by a meat press or lemon squeezer; or the meat may be chewed by the patient and the juice swallowed while the fiber is rejected. Two tablespoonfuls of Bovinine or an equivalent amount of any good beef extract in a wineglassful of water, not too warm, may answer nearly as well. Bovinine if a little table salt and celery salt be added to flavor it, is apt to agree with the weakest stomach, except when there is a deficiency or absence of the secretion of hydrochloric acid, and when the chemical analysis has shown this condition, the acid must be supplied as medicine. In very acute or severe cases smaller amounts of even the above simple foods will need be given at first.

Diet Table No. 3.

Take every two hours one or two glasses of good fresh milk, with a tablespoonful of limewater or a pinch of salt in it. It should be sipped slowly and may be preceded by the thorough mastication of half a slice of stale white wheaten bread, preferable well toasted, or the same quantity of unsweetened zwieback; or by two or three fresh gluten wafers, plain water crackers or soda crackers may be taken with the milk. Thin rice or barley gruel may in certain cases be mixed with the milk in the proportion of one-third gruel to two-thirds milk. No other food should be taken while on this diet.

Diet Table No. 4.

At any of the three usual meals a few of the following foods may be selected: They are mentioned in the order of their

excellence, those first named being more digestible and less fermentable than those which follow :—

Broiled lean beefsteak, lamb or mutton chop,—any of these scraped so as to obtain the pulp and juice, avoiding the fiber and fat; finely chopped lean beef made into little cakes after the removal of all the fat and gristle and then broiled over the coals; eggs soft-boiled, poached or scrambled in milk without butter or any fat; eggs and milk made into a baked custard without sugar; stale white wheaten bread, (the best home-made bread is preferable) well toasted as a rule, and a very little butter may be eaten on it; good fresh gluten wafers; zwieback, unsweetened; purée of celery, or peas, beans, white potatoes, corn or tomatoes, prepared in the same delicate manner—that is, first thoroughly cooked, then rubbed through a colander and made into a thin smooth purée with water, to which a little milk may be added, the whole being seasoned lightly with salt.

At the end of each meal a small cup of hot water with or without milk added to it, milk with lime water, peptonized milk, buttermilk, kumyss, matzoon, infusion of cocoa shells, of Caramel Cereal or of any good cereal preparation intended to imitate the flavor of coffee.

If hungry at 11 A.M. or at 4 P.M., sip slowly a glass of any of the above-mentioned nutritious beverages, eating at the same time, if desired, a few crackers or a piece of toast or zwieback.

Except in the cases in which the proper tests have shown weak motor power in the stomach walls, the patient may drink freely, though not more than a single gobletful at a time, of Poland Spring, Bethesda, clysmic, Buffalo lithia or Apollinaris water, or of any good pure water as little impregnated with mineral ingredients as possible, but not of any of the stronger alkaline waters unless especially prescribed by the physician. Rain-water or any soft water will answer the purpose well if boiled to destroy all germs and afterward cooled down and recharged with air to give it life by shaking it a few minutes in a bottle which is not entirely filled.

Foods and Drinks to be Particularly Avoided.

All articles not especially mentioned as permissible, and particularly all foods made or served with sugar, shell fish, fried things, muffins, fresh or hot rolls, soda biscuits, flannel cakes, etc.; bread not at least one day old; breads or other preparations made with coarse unbolted flour; fruits; vegetables except as above mentioned; nuts, raisins, candies, pastries, ices, cakes, puddings, twice-cooked or warmed-over meats, cheese, sausage and scrapple as well as vinegar and other very sour things, and all hot or sharp condiments, spices, etc.; also alcoholic beverages except as specially permitted. Vichy and the other strong alkaline waters should be avoided except when prescribed for hyperacidity as shown by a chemical analysis of the stomach contents. The long-continued use of these as well as of the saline laxative waters in cases for which they are unsuited, has done incalculable mischief to great numbers of dyspeptics.

Diet Table No. 5.

Selections may be made from any articles in the previous lists and from any in this table. None of these foods should be made or served with sugar or cooked with butter or other form of fat.

Soups.—None at all at dinner unless it is to be a very light meal; but at luncheon, or when required between meals, any plain simple soup not too rich or greasy.

Fish.—Raw oysters in their season but no other shell fish; any other kind of fish properly cooked except eel, cod, turbot, halibut; and all fried, dried and cured fish, which are to be avoided.

Meats.—Very tender, broiled, lean beefsteak, lamb chop, venison, antelope meat, hare or rabbit, chicken, squab, quail, or any edible bird except duck or goose; also boiled ham in moderation; broiled or stewed sweetbreads; any of the following roasts, if the fat and gristle are carefully rejected: beef, lamb, mutton, chicken and very sparingly of the white meat of turkey, but not the dressing of any roast fowl or meat.

Patients on this diet should not as a rule take both fish and meat at the same meal.

Eggs.—In all forms except fried; omelettes if baked and not fried; eggs in baked custards and light puddings if not prepared with sugar. Saccharin may be used instead.

Farinaceous.—White wheaten bread

at least one day old, and better two days old; toast or unsweetened zwieback; gluten wafers; plain water crackers; salt crackers or saltines; soda crackers; corn-bread made without sugar and with only the smallest amount of shortening, best in the form of the Southern hoe-cake or pone; rice cakes. Any of the breads may be lightly buttered. All the mushes (which are usually swallowed without chewing or admixture of the saliva) are purposely omitted from this list.

VEGETABLES.—White potatoes baked in their skins or boiled and mashed with milk instead of butter; stewed celery; spinach; boiled and finely mashed carrots or parsnips but not cooked with butter; string beans; young and very tender peas; and, merely as a relish, a leaf or two of lettuce or small piece of uncooked celery served with salt but no vinegar. Also any vegetable purée as described in Table No. 4, with the exception of the few of them that are mentioned above as permissible.

DESSERT.—A sweet orange, a baked sweet apple, or a few white grapes; after a luncheon or very light dinner, one egg made into a baked custard with milk, but without sugar. If sweetened with saccharin and flavored with vanilla, lemon or sherry, this makes a delicious dessert. Also, curds and whey without sugar; very sparingly of Iceland moss jelly or of guava or other fruit jelly; a small portion of malted milk or of Horlick's or Mellin's food served with fresh cream, but these jellied and malted foods are all too sweet to agree with many doubtful stomachs.

DRINKS.—Any of those mentioned in No. 4. or a glass of Apollinaris, Poland, Bethesda, Clysmic or Buffalo Lithia Water may be taken at the end of the meal.

Water may be drunk freely between meals, except in the cases of dilated stomachs, or of those in which the motility or propulsive power has been found to be deficient.

Patients should not take any foods or drinks not allowed in this or previous tables and avoid carefully all the things particularly forbidden in No. 4.

DIET TABLE NO. 6.

May take in addition to the articles mentioned in the previous lists:

SOUPS.—Small quantity of any kind not too rich or greasy.

FISH.—Oysters in their season in any form except fried; no other shell fish, but any of the other kinds not fried.

MEATS.—Any kind of cooked meats other than those fried, except corned beef, salt pork, very young veal and "high" game. Duck, goose, and even the dark meat of turkey should be eaten very sparingly, if at all, by persons whose digestion is doubtful, and the dressing should be avoided by them entirely. Boiled meats are far less digestible than those roasted or broiled as well as less nutritious.

EGGS.—In any form except fried hard or combined with sugar in rich desserts.

GRAINS OR CEREAL FOODS.—The drier forms, such as stale bread, toast and crackers, which require to be chewed, are always best; also corn bread, rye bread, brown wheaten bread and rolls; but a moderate amount of the mushes may be taken by patients whose intestinal digestion has been restored nearly to the normal. The best of them are Wheatena, thoroughly boiled rice, the finest grades of cracked wheat, if cooked over night in a double kettle, and the finest well-bolted kinds of oatmeal cooked in the same way. They should be eaten with a small amount of fresh cream or milk and mixed well with the saliva. Butter may be taken with the bread except at dinner, when it is better omitted.

VEGETABLES.—Any of the following well cooked but not fried: asparagus, beets, Brussell's sprouts, beans in purée, or very thoroughly boiled and afterward baked till brown; cauliflower, carrots, celery, dandelion, egg-plant (but not fried), mushrooms, onions, parsnips, tender young peas, parsley, potatoes, pumpkins, spinach, string beans, summer squash, sweet corn (if young and very tender), tomatoes, turnips, turnip tops, and vegetable oysters.

The following uncooked vegetables may be partaken of sparingly, merely as a relish, since they are difficult of digestion and have small food value: lettuce, olives, raw celery and cold slaw.

DESSERT.—Persons who have a tendency to indigestion or who have recently convalesced from attacks of it, should foreswear rich desserts and limit themselves in this respect mainly to the

fruits, etc., mentioned in the previous table, or take a small amount of one or two of the following: ripe peaches, pears, grapes, bananas, melons, light simple puddings not made very sweet, and very sparingly indeed of nuts, bearing in mind that these besides being difficult of digestion, are a very strong, heavy food, and therefore very unsuitable to follow a hearty meal. Ice cream and water ice are borne fairly well by many not robust stomachs, if taken as part of a light lunch, yet often disagree when taken, as is the absurd American habit, at the end of a dinner, since all ice-cold foods or drinks may easily cool down the stomach contents below the point at which digestion is possible.

DRINKS.—Cocoa or chocolate; very moderately of coffee or tea not too strong. The lighter wines may be taken by those accustomed to them, except where there is a tendency to hyperacidity — especially to an excess of hydrochloric acid in the gastric juice, as shown by a chemical analysis, and this should be made in all doubtful cases. The best of ales, beers, or liquid malt extracts are also permissible in certain cases with the same exceptions, since they are all acid. In cases where a stimulant is really indicated, a very small portion of whiskey in water is often safer.

To be avoided are very rich, very sweet or complicated dishes; articles fried in fat; soda biscuits and all hot breads as a general rule; most kinds of shell fish, except oysters in their season; pastries, ices after a full meal; sausage, scrapple and warmed-over meats; very strong coffee or tea, and large quantities of any coffee or tea; alcoholic beverages, except under the conditions and restrictions above mentioned. Vinegar and the sharper condiments, such as pepper, mustard, and the hot sauces need to be either avoided or taken sparingly by patients who have recently shown a tendency to an excess of hydrochloric acid in their gastric juice.

Nos. 1 and 2 are suited to acute and subacute gastritis or cases of irritable stomach from whatever cause. Aided by appropriate medicines and other accessory measures, such a regimen should be speedily effectual, and not need as a rule to be continued beyond a few days.

The articles prescribed in No. 3 usually agree well with cases of subacute gastric catarrh and with certain forms of chronic gastric catarrh; also, with nephritis and any of the other conditions for which a milk diet may be indicated. Out of the first three tables can be formed a good regimen for gastric cancer.

No. 4 is adapted to a large proportion of the cases of chronic catarrh of the stomach (gastritis glandularis chronica) of pronounced type in the stage in which they are usually first seen by the specialist. Combinations of 3 and 4 with some omissions are useful in gastric ulcer.

No. 5 is intended especially for the same classes of diseases when somewhat further advanced toward a cure. With some modifications, especially in the direction of restricting the amount of meat, both Nos. 4 and 5 may be suited to the treatment of the different degrees or stages of hyperchlorhydria*; also to the management of numerous other chronic affections in which a simple and easily digestible and yet highly nutritious diet is required.

No. 6 is too liberal to be entirely safe for most dyspeptics even when convalescent, but it serves the very useful purpose of encouraging them to look forward to it as comparatively a feast of good things to which they may hope to attain later on, and at all events it is a vastly simpler and safer diet than that to which most of them have been accustomed, and than that to which they would promptly return upon being pronounced convalescent, unless peremptorily limited to a less harmful one by their physician. It can easily be cut down to the exact needs of any particular case. By a little modifying it can be suited also to diabetes, obesity, lithemia and numerous other diseases.

For catarrhal inflammations involving both the stomach and intestines, the lists 1 to 4 may be employed, the more restricted ones for acute or severe cases, and No. 4, or even No. 5, for the chronic ones and those progressing toward recovery. When the catarrh is confined wholly or mainly to the intestinal mucous membrane, the gastric juice being active and the stomach as a whole in good condition, the rather

*A paper by the writer, which is to appear in the next volume of *International Clinics*, further discusses this subject of diet in hyperchlorhydria.

fashionable American dietetic treatment by lean meat and hot water with the addition of toast and a few relishes, often suits remarkably well if not persisted in too long. Such a plan of diet can easily be adapted from No. 4 or No. 5 by striking off the vegetables and other articles not required. Aberrations from the normal in the amount or character of the gastric juice—whether they constitute hyperpepsia or hypopepsia—demand special dietetic treatment which can be readily met by modifications or combinations of these tables.

SEVERAL CASES OF PSORIASIS SHOWING AN INCISED OR CONTUSED WOUND AS THE INITIAL POINT OF ATTACK.

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Within the past two years I have had presented, either at my private offices or at one of my clinical services, several cases of psoriasis wherein the statements of those afflicted have implied that the disease had begun after some form of wound, and thinking that these, fully reported, would be of service to some of the profession, I include the full history of each case as given by the person afflicted and what was elicited from subjective examination at the time of the visit of each.

The first of these to come under my notice was witnessed in a young man of twenty-five years of age and a plasterer by occupation who applied for treatment at the Philadelphia Polyclinic. He stated that the condition for which he sought advice was of two months' duration and that it had first made its appearance upon the left forearm at a point on its external aspect about midway between the elbow and shoulders. This initial point corresponded to the place where he had had a knife thrust at him just two weeks before the appearance of the present trouble.

Upon closely examining the condition of the body at this visit I saw at the point of the knife thrust a large patch of psoriasis showing in all the characteristic appearances of this disease, but I should not have been satisfied that this was a true psoriasis were it not for the fact that the remaining portions of the body were covered with similar lesions. For instance, both upon the chest and back there were numerous isolated or discrete characteristic patches of psoriasis, while at different portions of these regions and upon both extremities there were numerous irregularly-shaped lesions, showing that a number of smaller ones had coalesced into larger patches.

All of these lesions were covered with the characteristic mother-of-pearl, or silvery-white laminated scale, so peculiar to this disease. Upon removing any of these scales we could discern the usual bleeding points so often found in this affection.

The young man gave the following family history: Both his father and mother, his brothers, three in number, and his sisters, two in number, had never suffered from any similar complaint nor did he ever have a similar disease; in fact, he stated that he never had had any eruption upon the skin whatsoever, nor had there been any eruption of this nature in any of the grandparents or their offspring.

In referring to the thrust of the knife, which he believed had been the cause of the disease, he stated that about two weeks before the present trouble he had been in the company of some friends and that in wrestling for the possession of the knife he was punctured at the point above mentioned. He immediately had the wound, which he stated was only about one inch in depth, dressed and in the course of ten days it was entirely healed. A few days later he had noticed the appearance of the psoriasis which had spread from this

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point until it covered the parts now affected. He had not had treatment for this condition until he appeared at my clinic. Under appropriate measures the disease was entirely cured in about three months.

The second case of psoriasis, giving an almost similar history, was brought to my private offices by Dr. Charles D. Spivak, who was living in Philadelphia at the time. This also happened in a young man of some twenty years of age who presented a well scattered eruption over the greater portion of the body—some of the lesions being small and discrete while others were large and still others showed coalescence. The disease in this instance had first made its appearance upon the anterior surface of the right leg slightly above its lower third and directly over the tibia, running to some distance beyond this region, being some two inches in diameter at the time of examination.

The family history of this young man did not present another case of psoriasis nor of any skin eruption, although the history was carried back to the fourth generation upon both the paternal and maternal branches.

The history was that several months before the appearance of the psoriasis he had had a bruise upon the site of this initial lesion caused by a hammer dropping out of his hand while he was at work. This had entirely skinned a portion of the region along the tibia, but receiving proper treatment at the hands of his family physician, had healed in a short time. He further states that the present eruption has existed for about three months and that it gradually came out upon different portions of the body after it had first appeared at the site above mentioned. It has gradually appeared over the greater portion of the body but as it gave him little or no trouble until his visit to Dr. Spivak he had not sought medical advice until that time. I am unable to state the course of this disease because of the disappearance of the young man from treatment.

Another instance of this disease having first showed itself at the point of some injury was witnessed at the Southern Dispensary, of Philadelphia, while I was dermatologist to that institution. The child, a female, was brought to the service by its grandmother who gave the age as seven years and stated that the eruption for which she sought advice had been of three months' duration. Upon closely questioning her as to the antecedent history of the child's parents we could not detect any similar disease throughout the entire paternal and maternal branches.

Being of Jewish parentage of the type which have lately come to our shores, that is of the lower Russian element, it was rather difficult to elicit this history because not one of my assistants were able to distinctly understand what they wished to imply. The woman stated that the child had been vaccinated some time previous to appearance of the present condition but that this sore had entirely healed some time before the appearance of the psoriasis eruption. The eruption of psoriasis covered a great portion of the child's body in small and large discrete lesions while in the number some coalescence had been noted.

A similar condition to that which I have reported in these lines was witnessed by G. Rioblanc (*Monatshefte f. prakt. Dermatol.*, xxii, February, 1896) who saw the appearance of psoriasis after vaccinating a soldier twenty-two years of age. This author also refers to ten cases which were somewhat similar in appearance and he believes that the condition was due to hereditary disposition, favored by the vaccinal irritation. I offer no reason in the cases that I have included but hope that some definite reason may be forthcoming in the near future.

Strange Cure for Whooping Cough.

A magician in Belfast, says the *London Mail*, has discovered a new cure for whooping cough. You pass the afflicted child three times under the belly of an ass, and then both child and ass eat oatcake out of the child's lap. We suppose the theory is that the cough passes into the donkey, and an extra whoop or two when he coughs makes little difference to him. Unhappily a child so treated died—of bronchitis. But, as the Court sagaciously held, no blame attached to the parents, nor to the magician. Nor yet, we feel bound to add, to the donkey.

CURRENT LITERATURE CONDENSED.

A Case of Foreign Body in the Vitreous.[1]

The patient, J. J., was wounded by the explosion of a copper dynamite cartridge, January 18, 1890. The fragment entered the sclera of the left eye, 7 to 8 mm. to the nasal side of the corneal limbus. Blood filled the anterior chamber for two days. After absorption, the foreign body could be seen in the vitreous, opposite the base of the iris, on the temporal side. A drawing made at this time represents exactly its present position and appearance.

One year later, there was a moderate hyalitis of unknown origin, and confined to this eye, ending in complete recovery. The patient was treated at this time by the late Dr. George T. Lewis, whose notes furnish the above facts.

The boy consulted me first in March, 1896, on account of accommodative asthenopia. A weak hyperopic cylinder relieved the symptoms and gave normal vision, which has continued. The presence and unaltered position of a piece of copper for seven years, without irritation, give interest to the case, and particularly in view of the opinion of Leber and others, that copper is more dangerous to the safety of the eye than other metals.

In this case, the fragment has become lightly encysted and gives no metallic reflex, excepting in a very dark room, where it emits to the illumination of the ophthalmoscopic mirror a reddish tinge.

Successful Removal of a Piece of Steel from Vitreous by Use of a Magnet.[2]

J. S. received a small fragment of metal in the left eye in April, 1896. After the transient discomfort had subsided, he gave the accident no further thought, until it was revived in his memory by the questions asked when he applied in October at the Jefferson Hospital, on account of failing vision and inflammation in the eye.

A bright reflecting piece of metal could be readily seen with the ophthalmoscope, floating in the vitreous, and a small scar below, and to the outside of the corneal limbus, was found, after careful searching, V. $\frac{20}{200}$. An incision through the conjunctiva and sclera, between the external and inferior rectus, was made, through which the smallest tip of the Hirschberg magnet was inserted.

After two unsuccessful efforts, a small triangular, corroded piece of steel was removed, with the loss of an insignificant amount of vitreous. In one week the vision was $\frac{20}{30}$.

Three points may be noticed in connection with this case; namely, the comparatively long time between the entrance of the steel and its removal, the retraction of the edges of the scleral cut as the tip of the magnet was withdrawn, and the recovery of excellent vision.

Epithelioma of the Corneo-Scleral Junction.[3]

The condition was found in a sixty-nine-years'-old man. The growth first manifested itself as a small "pimple" at the lower outer corneal border of the right eye, and gradually and painlessly increased in size. When first seen, it appeared as a fleshy and wart-like looking mass, about the size of a pea, and embraced an area equal to almost the lower outer quadrant of the cornea.

In spite of careful excision with free thermo-cauterization, repeated more extensively some two months later, the mass recurred until, in four months' time, it had become so great in size and so angry in appearance that the eyeball, with the surrounding conjunctiva, was removed, the operation, by reason of renal and cardiac disease in a weak and feeble patient, being almost painlessly done during local anesthesia by the use of hydrochlorate of cocaine. Up to the present writing, there has not been any recurrence.

From a clinical standpoint, the case is most interesting. Commencing as a "pimple" in the epithelial structures

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[2] Dr. Howard F. Hansell, before Section of Ophthalmology, Philadelphia College of Physicians.

[3] Dr. Charles A. Oliver, before the Section of Ophthalmology of the Philadelphia College of Physicians.

of the conjunctiva at the transition-border between the cornea and sclera, as is almost universal in such cases, the mass gradually and painlessly increased in size until it assumed the papillomatous variety of growth. It then extended into and beneath the epithelium of the cornea, far in toward the summit of the membrane. In other words, the tumor-mass evidenced its development and growth in a manner that is eminently characteristic of epitheliomatous formations.

The quick recurrence and steady increase of the growth, in defiance of the extreme radical measures employed for extirpation, manifestly evidenced the necessity of removal of the entire field of malignancy. The almost uncontrollable oozing of blood, experienced during the operative procedure, plainly showed the extreme vascularity of the neoplasm.

Microscopically, the specimen was exceedingly instructive, not only by reason of presenting the characteristic appearance of epitheliomatous formation in the region involved, but upon account of the undoubted protrusion of the epithelial cells into the interlamellar corneal spaces (which, possibly, might have been produced or rendered more easy by the operative procedures pursued in the earlier stages of the disease), and the insertion of the same form of malignant cells into the superficial layers of the sclera (layers which were untouched by operation); but is also of great interest in substantiating the view that the deepest penetrations of the epithelial cells into the outermost tunics of the eye were in the transition-zone between the cornea and the sclera—that is, at the corneo-scleral junction.

Unilateral Albuminuric Retinitis.[4]

After a brief review of the literature of unilateral albuminuric retinitis, during which reference was made to fifteen cases, Dr. de Schweinitz reported two examples that had come under his care, both in colored men. In the one instance clinical examination indicated chronic nephritis, and there was unilateral neuro-retinitis. The patient, however, was not seen again and his subsequent history was unknown. In the second case the patient had been under observation for five months, and had all the symptoms of chronic interstitial nephritis with unilateral (right side) retinal lesions.

Water colors by Miss Washington, illustrating the condition in two stages, were presented, indicating that the primary lesion had probably been a thrombosis in the lower nasal vein with secondary involvement of the disc and retina.

Dr. de Schweinitz agreed with Knies that unilateral albuminuric retinitis is not so great a rarity as some text-books would lead us to believe. A certain percentage of cases maintain monocular retinal lesions until death; in another the unilateral character of the affection is maintained for a considerable portion of time, but ultimately becomes bilateral.

Dr. de Schweinitz suggested that an interesting clinical observation in these unilateral cases would result from catheterization of the ureters and separate analysis of the urine from each kidney. His patient had declined to submit to this procedure.

Report of Successful Removal of a Piece of Steel from the Vitreous by the Hirschberg Magnet.[5]

J. S., aged twenty-eight, was admitted to the wards of the Episcopal Hospital, June, 1896. Six hours previously a piece of steel from an anvil penetrated the right lower lid and the ocular coats, and was lodged in the nasal side of the anterior portion of the vitreous where its position could be distinctly outlined. The cornea, iris, and lens were uninjured. A minute bead of vitreous protruded from the wound in the sclera. The choroid was ruptured and retinal hemorrhage was profuse at the site of the injury, V. $\frac{20}{200}$.

The following day, under antisepsis and cocain anesthesia, an incision was made with a Graefe knife through the conjunctiva and sclera 6 mm. from the corneal border and opposite its lower third. While the edges were retraced by an assistant, the straight tip of a Hirschberg magnet was inserted. Upon withdrawal of the magnet, after its

[4] G. E. de Schweinitz, M.D., before the Section on Ophthalmology, College of Physicians of Philadelphia.

[5] G. Oram Ring, M.D., before the Section on Ophthalmology, Philadelphia College of Physicians.

second introduction, a piece of steel 6 x 2 x 1 mm. was found clinging to it. No sutures were used.

Recovery was prompt and uneventful. A patch of atrophied choroid corresponding to the rupture can be seen through the now transparent vitreous. The vision has increased to $\frac{20}{70}$.

Jaundice and Perforation of the Gall-Bladder in Typhoid Fever.[6]

At a recent meeting of the Royal Medical and Chirurgical Society Hawkins reported the case of a woman, eighteen years old, in whom in the course of an attack of typhoid fever there appeared pain in the abdomen and back, with tympanites, enlargement of the liver and increased frequency of respiration. For the first five days there was constant pain in the back and legs, with rejection of food, looseness of the bowels and nocturnal delirium.

A day later severe pain was experienced in the right half of the epigastric region and over the right lower axillary and hypochondriac regions. The respiration had increased to forty per minute and there was evidence of dry pleurisy at the base of the right chest. Vomiting became constant and the temperature rose to 105.8°. After another day the conjunctivæ and the skin of the upper half of the body became jaundiced; bile was found in the urine and the stools were frothy and white.

The jaundice increased and the pain on the right side of the chest became more severe and extended to the umbilicus, the region of the gall-bladder becoming exquisitely tender. Later the stools were passed unconsciously; at times they contained bile. The respiration which was principally abdominal, was accelerated and at one time reached a frequency of eighty. To the right-sided pleurisy similar involvement of the left side became finally added. Now the pain in the epigastrium lessened and ultimately disappeared.

Hemorrhage from the bowels was more or less constant for a period of nine days, and death took place from the pulmonary complications on the twenty-third day. The jaundice persisted until death, although it was absent for one day except from the conjunctivæ.

Upon post-mortem examination, in addition to ulceration of the ileum and colon, adhesions between the gall-bladder, the stomach and the peritoneum were found. The cyst duct contained an easily movable gall-stone. The gall-bladder contained pus and its anterior wall was perforated. The liver was uniformly enlarged and showed cloudy swelling but no bile exuded. The jaundice was attributed to the suppuration of the gall-bladder.

Deficiency of Pigment, Allowing the Fundus Reflex to Show Through the Iris.[7]

At a former meeting of the Section he had shown a similar case. Both of these patients had undergone cataract extraction; in the one shown this evening, there was rupture of the sphincter, the lens having proven to be larger than the average. It was the only time he had met this accident in simple extraction.

The fundus reflex showed through other parts of the iris almost as readily as through the part at which the rupture had occurred. Possibly it might be that there were other ruptures of the iris, but the distribution of the fundus reflex was entirely different from that indicating rupture of the iris. It constituted a general area of red, against which the details of the iris were seen. It was rather a rounded area, and did not consist of fissures through which red reflex could be obtained.

It could hardly be regarded as a rupture of the posterior layer of the iris, because there was no change in the outline of the pupil. There was no deformity of the pupil in the case previously reported. Rupture of the posterior layer would necessarily cause deformity in the pupil, certainly a rupture of such considerable size. The posterior layer opposes the action of the sphincter, and the two together give the pupil its form.

It is quite possible that this appearance is the result of atrophy of the pigment cells from stretching of the iris, but probably it is simply an atrophy comparable to the changes in the choroid in the eyes of many old people. Attention is called to this condition, one that

[6] *British Medical Journal*, January 30, 1897, p. 266.

[7] Dr. Edward Jackson, before the Philadelphia College of Physicians, Section of Ophthalmology.

may readily be overlooked, since it is perhaps more common than the two cases would seem to indicate. It is brought out while illuminating the fundus as much as possible, at the same time leaving the affected part of the iris in comparative darkness.

As only three weeks had elapsed since the extraction, the time was too short for any extensive atrophy to occur. The pigment of the iris was not rubbed off by the lens in its passage through the pupil.

Immature Infants in France.[5]

That the threatening depopulation of France is a most serious misfortune against which our neighbors are striving in a variety of ways and with greater or less success, cannot, unfortunately, be gainsaid, but even in this lamentable case the old proverb, "'Tis an ill wind that blows nobody good," may be applied with perfect accuracy. A persistently diminishing birth-rate might well be looked upon as an evil out of which no benefit could possibly arise, and yet with respect to one fragile, but by no means unimportant, section of the French community the national unfruitfulness has proved itself to be a veritable blessing in disguise.

The heretofore forlorn beings who have thus fortuitously derived benefit from the general calamity are the newly-born infants, who from various causes, but chiefly by reason of their premature appearance on the scene, are peculiarly unfitted to withstand

> "the thousand natural shocks
> That flesh is heir to."

Formerly no very serious efforts were made to prolong the ephemeral existence of these unwelcome little strangers. They were rather hopelessly allowed to pine away and die, under the impression that they could not possibly survive, but human life has of late become so valuable in France that no breathing waif need now be abandoned as an irretrievable derelict.

Little children have ever been esteemed the most precious of human possessions all the world over, but it was reserved for an energetic Frenchman to set the seal upon this preciousness by conserving the immature specimens in glass cases. This is a truly remarkable institution, which owes its inception and development to the zeal and philanthropy of Dr. Alexandre Lion, of Nice.

Ruminating one day on the perilous condition of his country from a demographic point of view, it struck this patriotic and humane member of the medical profession that the holocaust among prematurely born infants would be largely diminished if the helpless atoms could only be kept sufficiently warm. Accordingly, in 1891 he invented his *couveuse*, or modified incubator, which may briefly be described as a woven wire mattress suspended in a glass case, the latter being heated by a water coil and kept sweet and wholesome by a constant inflow of purified filtered air.

The success attending on this new departure in infant life preservation has been surprising. A prematurely born child, if exempt from hereditary disease, never dies in Dr. Lion's institute provided it weighs not less than two and a quarter pounds—that is, about one-third of the normal standard—and provided, also, that its installation in the *couveuse* is accomplished with the least possible delay and exposure. At this stage of the untimely bud's frail existence a chill is almost certainly fatal, so the transfer from the lying-in bed cannot take place too soon or be carried out too carefully.

The theory that immature infants require exceptional warmth is, of course, not a new one. Every midwife knows the importance in such cases of immediate swaddling; and children born before their time, whose survival was regarded as well-nigh hopeless, have ere now been saved by such devices as enwrapment in newly-flayed skins, the utilization as cradles of freshly eviscerated sheep and goats, etc. The inventor of the *couveuse*, nevertheless, amply deserves the lion's share of the credit, not merely on account of his ingenious amplification of a well-known principle, but also for his untiring advocacy and capable organization.

In diseases of the thorax radioscopy gives information comparable in all points to that obtained by percussion.

5 *British Medical Journal.*

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PHILADELPHIA, SATURDAY, FEBRUARY 27, 1897.

EDITORIAL.

SUICIDE AMONG PHYSICIANS.

During the last three years, the number of suicides occurring among physicians has been, respectively, forty-five, fifty-nine and forty-seven per annum, an average of nearly 1 to 2000, or as the death-rate among the physicians is about 25 to 1000, nearly one-fiftieth of all deaths in our profession have been by suicide. This is a conservative estimate, as many instances—doubtless most of our readers can recall one or two—of death are attributed to accidental overdosing with a narcotic and as the tendency is always to hush up a suicide whenever possible.

In our estimation, the very prevalent custom of saying that a physician has died of an overdose of morphine or chloral, self-administered, is an insult to the professional skill of the deceased and to the penetration of the laity. But without including such cases, the fact remains that our profession is more prone to suicide than any other.

In commenting on these statistics, the *Bulletin* of New York suggests that they may be explained by the development of morbid fancies in the mind of a doctor, on account of his constant association with the sick and dying, or of an actual indifference to death, or because he has the requisite knowledge of how to die conveniently and painlessly. We are hardly inclined to accept either of the first two theories, except that the latter may apply to the physician as to

any other man thoroughly and practically instructed in the realities of life and belonging to a profession that for some inexplicable reason seems to tend toward materialistic ideas.

The question forces itself on our minds, in every consideration of suicide, is the self-murderer a coward? Some suicides have gone to the trouble of selecting the most agonizing forms of death in order to disprove the assertion so commonly made. One man, for instance, arranged a number of candles on a board and placed himself in a support above them, so that they burned his back and produced death by lesion if not actual charring of the spinal cord.

But we can hardly demand any such proof as this, even to settle the question of the physical courage of the suicide. No one is a coward for avoiding wholly unnecessary pain and the suicide who selects a revolting and disfiguring or even unclean mode of death adds to the burden of the living and has in no way mitigated his own sin.

In our own opinion, the ethics of suicide depends wholly on religious belief. If we considered the human being simply a body moved in various ways by the secretion or chemical activity of certain nervous cells, we should consider the stoppage of this secretion or chemical activity as perfectly justifiable, even if other bodies similarly actuated by material processes would manifest peculiar phenomena which the uninstructed call grief, at the cessation of the cerebral secretion in others.

On the other hand, a suicide by a person convinced of the truth of orthodox. Christianity is scarcely what can be termed cowardice. Intervening stages of religious conviction may properly allow the suicide to be considered as a coward in attempting to escape the trials set before him in this life.

We do not believe that the painfulness of dying is a matter upon which the average would-be suicide bestows much thought. He may consult his own convenience and that of survivors by selecting a mode of death that is bloodless and something like personal vanity, since at least respect of dress and appearance, is manifested by a large proportion of suicides. Thus, poisoning is a favorite method, but it does not appear from statistics that the cyanids or morphin have the preference which would exist if epicurean philosophy were carried into the choice of drugs. At the same time, physicians usually put their knowledge of drugs to a practical execution in selecting a poison for suicide.

But if the mere knowledge of the painlessness of death by certain means is not a determining factor in leading so many physicians to suicide, probably the accessibility of poisons is. Suicide is largely a matter of insane impulse and such an impulse can often be ascertained even in the case of those who have long been indifferent to life and have contemplated suicide. Imagine a man fatigued in body and depressed in spirits,—as the doctor very often is,—with an impulse to suicide. If he must put on his hat and overcoat, walk to a drug store and tax his ingenuity for a lie with which to explain his desire for poison, he may postpone the fatal act from mere inertia or he may meet a friend or have his interest in life aroused by one of a multitude of every-day occurrences or physical exercise may bring him to his senses. If, as is the case with almost every doctor, he has simply to feel in his pocket or walk across his office to get a deadly poison, the impulse may be carried into execution before anything can happen to supplant it in the brain.

Behind the question of suicidal impulse and the means of executing it, lies the question of general or predisposing causes to suicide, that is, such as pro-

duce the impression that life is not worth living. Longfellow has beautifully taught, in his "Dreary Day," the only true philosophy regarding discontent with life. "Into each life, some rain must fall" applies to the physician as to every other man but are there special reasons for discontent which apply with exaggerated force to the physicians? We believe that there are.

Aside from the pleasure of working in natural channels of interest, the practice of medicine affords little in return for the demands which it makes. The doctor, like the teacher, lacks the stimulation of men's society but, unlike the teacher, he has no compensation of short hours and holidays. Like the minister, he has many ethical and moral burdens to bear but without the loyal support which the latter enjoys if his work is performed well. As compared with legal and business prospects, the doctor's hopes of success are limited while his leisure is broken up by the exigencies of practice. With his confréres, the physician is altogether too apt to be disturbed by petty jealousies while he is rendered envious by seeing old friends in other vocations either forging ahead of him financially or, if poor, enjoying the opportunity for economical pleasures for which he himself has no time.

All this is the inevitable result of dividing the pay and employment of one man among several and the preponderance of suicides and of men who feel that their lives have been failures, will continue in evidence, so long as men flock into the profession without realizing that it has almost nothing to offer pecuniarily. When the conception becomes general that medicine is a "poor trade," that there are three times as many physicians in the country as can well be supported and that only a well-established predilection for the work makes it wise or right for a man to seek admission to our ranks, then, and not till then, can we expect a lowering of the abnormal percentage of unnatural deaths among physicians.

For those already in the profession, a few words of advice may not be out of order. Get the greatest possible amount of innocent enjoyment out of life. Do not give up society, the theatre, and other means of adding diversity to your routine, because you are fatigued or because you are sometimes prevented from keeping appointments of this nature. Cultivate a cheerful spirit and do not be annoyed at the envy or superciliousness of your professional colleagues or the criticisms and ingratitude of patients.

If this is impossible, and the impulse to seek death will come, commit suicide as a physician, not as a human being. In other words, if you cannot succeed or cannot philosophically accept what your profession has to offer, get out of it and give someone else a chance, while you give yourself the chance to live more more happily in more congenial surroundings.

Tongue Twisters.

Read the following aloud, repeating the shorter ones quickly half-a-dozen times in succession:

Six thick thistle sticks.

Flesh of freshly fried flying-fish.

The sea ceaseth, but it sufficeth us.

Give Grimes Jim's great gilt gig whip.

Two toads, totally tired, tried to trot to Tedbury.

Strict, strong Stephen Stringer snared six sickly silky snakes.

She stood at the door of Mrs. Smith's fish-sauce shop, welcoming him in.

Swan swam over the sea; swim, Swan, swim; Swan swam back again; well swum, Swan.

A haddock, a haddock, a black-spotted haddock, a black spot on the black back of a black-spotted haddock.

Susan shineth shoes and socks; socks and shoes shines Susan. She ceaseth shining shoes and socks, for shoes and socks shock Susan.—*Chatterbox*, Boston.

ABSTRACTS.

THE CAUSES OF THE FAILURE OF DRUG THERAPEUTICS.*

REYNOLD W. WILCOX, M.D., LL.D., NEW YORK.†

The primary cause of therapeutic skepticism, if you wish to term it so, lies in the teaching of the under-graduate schools. The subject of materia medica is by no means attractive, if, in fact, it can be made attractive. The professor takes up one drug after another, frequently without any evident physiologic or botanic relationship, and it may be, as it has become the fashion in the last few years, alphabetically, and because cassia fistula and castanea both begin with "C," the lecturer proceeds from one to the other. As a result, the students are graduated without any definite idea as to the relation of drugs to each other, so that the study of materia medica becomes a matter of memory in the same way as the study of anatomy has been in the past, and to a great extent is to-day.

I, myself, have heard in an undergraduate school, a lecture on ipecac in something of this style:

"Ipecac is a root which comes from Brazil—where the nuts come from. It has two alkaloids, emetine and cephæline. There is a syrup, a wine and a fluid extract and troches. It enters into morphine and ipecac troches, Dover's powder, and tincture of opium and ipecac. It is given to children as an expectorant, in cases of poisoning as an emetic, and in India it is used as a remedy in dysentery." The lecturer omits to state the differences between the action of the two alkaloids, how it acts as an emetic, and, in fact, the most essential points of all. That is not a fair sample of the teaching, but such is common in a great many undergraduate schools.

If proof were wanting that the teaching is imperfect I would only cite the experience which every examiner of candidates for positions on a hospital staff has had. It has always been my custom in examining these candidates to divide the examination, making part upon therapeutics and part upon medicine. I have never yet found a man that could pass a therapeutic examination which was at all comparable in point of quality with that which he passes on the subject of medicine.

I took occasion, not long ago, to look over a series of prescriptions which were collected from a pharmacy to which the best practitioners in the city direct their patients. From 500 consecutive prescriptions, written by 118 different physicians, I found the following facts: That in these prescriptions there were special preparations ordered, principally of iron or of the hypophosphites which are mostly inferior to the corresponding preparations of the Pharmacopeia and the National Formulary, twenty-nine (5.80 per cent.). There were sixty-three prescriptions (12.60 per cent.) which contained, or were entirely composed of, proprietary drugs, principally of the coal-tar series. There were of unofficial preparations, such as apiol, which are not patented, and which are not supposed to be of sufficient importance to be admitted to the Pharmacopeia—thirty (6 per cent.). Of these preparations I found thirty-six (7.20 per cent.) which were chemically incompatible. I found thirty-one (6.20 per cent.) which presented physiologic incompatibility; not the physiologic incompatibility which we purposely produce, but an incompatibility manifestly not intended nor expected.

Now to sum up these 500 prescriptions: There were 189 that were departures from the standard scientific productions, that is, 37.80 per cent. They were from

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a pharmacy where some of the best pharmaceutical work in the city is done, and I presume they were, to a large extent, from the best educated physicians of this city. That speaks for itself, as to the teaching that is prevalent in the schools. I do not criticize these prescriptions from the standpoint of accurate medical terminology although very few were written in good pharmacopeial Latin. Nor do I criticize them from any other standpoint. This exhibit shows that they were prescriptions that ought not to have been written, to a very large extent would not have been written if the Pharmacopeia and materia medica had been thoroughly studied during undergraduate days.

It has been stated that a medical consultation does not give the results that a surgical consultation gives- that there is not the definite result, so far as the progress of the patient toward recovery is concerned. I think perhaps one reason for this may be the fact that in the surgical consultation the consultant usually performs the operation or has it immediately under his charge, while in the medical consultation very largely the consultant takes it for granted that the physician who is to continue in attendance can carry out the treatment as he himself would carry it out. I know that frequently this can not be done, and a certain amount of criticism necessarily falls on the medical consultant. These are conditions that I am sure are attributable, to a considerable extent, to the imperfect teaching of the schools.

So far as drugs themselves are concerned, there are a certain number of facts that ought to be presented. In the first place, we can look for causes of failure in drug adulterations. I took occasion a few days ago to go over the report of the New York State Board of Health for 1895, where the results of analysis of 2,289 drugs which were collected in different cities of this state, on prescriptions written exactly in accordance with the terms of the United States Pharmacopeia. These are the results of an official analysis of these drugs: Of the 2,289 samples there were of good quality, 1,307 (57.1 per cent); of fair quality, 284 (12.4 per cent.); of inferior quality, 598 (26 per cent.). There were drugs not so called for (which I will explain later) 41, (1.8 per cent.), and drugs of excessive strength 59 (2.6 per cent.). So that the inferior or otherwise unsatisfactory drugs were 30.5 per cent. of the whole. The report goes on to congratulate the pharmacists themselves that this showing of 30.5 per cent. not up to the pharmacopeial standard was an improvement over the last year which showed 39.7 per cent. Of course this is a worse showing than a sample of all pharmacopeial drugs would be, because these were drugs selected for analysis, which were known to be most frequently adulterated.

Some of the variations from the official standard I have noted. Diluted acetic acid, a six per cent. solution, according to the Pharmacopeia; the specimens collected varied from 1.10 per cent. to 35.60 per cent. in strength, and all these were dispensed under the name, diluted acetic acid.

Creosote. Of the ninety samples collected, forty-six were good, six were poor, and thirty-eight were chiefly composed of carbolic acid.

Of ether, 230 samples collected, 116 were good, 5 fair, and 106, almost one-half, were inferior. And when the prescription was sent in for ether, in three instances other substances were furnished for ordinary ether. Once chloric ether was furnished, and twice spirit of nitrous ether. This is, I think, the most flagrant example of variation from the standard of pharmacopeial requirements.

Tincture of iodine. Of 205 samples collected, 39 were good, 88 fair and 75 inferior; 3 of excessive strength. Even whiskey is unsatisfactory according to the standard of the State Analyst; of the 76 samples 22 only were good, 10 fair and 44 inferior; so that even the whiskey of the pharmacy is not of the pharmacopeial standard.

We have a second cause of failure in the various trade formulas that appear, leading, as you know, to routine prescribing. For instance, the various iron preparations and hypo-phosphite preparations, whose name is legion, and various so-called private formulas of various physicians. Take one instance, the well-known rhinitic tablet, so called, which consists of camphor, quinine and

extract of belladonna, or atropin. Now, we prescribe the rhinitic tablet, and we get a certain number of good results. Suppose we have a patient who has a disturbance in the middle ear, to whom we do not care to give quinine. There may be another patient to whom we can not give atropin or belladonna, which would produce a disagreeable dryness in the throat and increase his cough; and there may be other cases where camphor would be an objectionable drug. Thus the making use of a ready-made tablet which may or may not be entirely appropriate, leads to the habit of prescribing various trade formulas, and militates very markedly against success in the use of drugs.

As for unsuitable preparations, there could be a great deal said. Every few days I hear of some new preparation and some combination hitherto supposed to be chemically impossible. They always appeal to me as matters of chemical interest, of pharmaceutic interest, but their real value to practitioners of medicine is not quite apparent.

What I have said concerning ready-made tablets applies also to many tablet triturates, but in a different way. The necessity for palatable prescribing has led to the placing of most unsuitable substances in this form. Instances might be given of volatile drugs, as aromatic spirit of ammonia, nitro-glycerin, or incompatibles, as lactopeptin with salol. Nor have the manufacturers been content with these, but they have assumed therapeutic knowledge when they dub their products "anti-asthmatic tablets," etc., thus making the physician a sort of nickel in-the-slot machine. These causes are independent of the physician himself. They are dependent upon the teaching in schools which make their own rules, and upon a matter over which the physician has a great deal of difficulty in acquiring control; that is, the management of the drug stores.

If I should mention what I believe to be the most potent cause of the failure of drug therapeutics, so far as the physician himself is concerned, I would say it is therapeutic nihilism which has been prevalent a number of years. At this time when we are making such tremendous strides in pure medicine, in drug therapeutics, we are ready to make comparison with the results obtained in any specialty, so that it seems to me that the man who to-day proclaims himself a therapeutic nihilist, simply proclaims himself a therapeutic ignoramus. There was a time when we did, solely and entirely with empiricism, to determine the value of drugs. It seems to me we have gotten entirely too far advanced to proclaim a disbelief in the efficiency of certain drugs.

Then again, so far as the physician goes, he is the victim to a considerable extent of routine prescribing. We begin in our hospital experience. As we follow the attending physician we learn that he has a particular formula for a particular disease, and we are quite apt to take the name of the disease as a peg upon which to hang the prescription. We go into our dispensaries and meet these formulas. We are told that mixture A contains so much tincture of iron chlorid, some tincture of cinchona, and water, and mixture B so much tincture of gentian, tincture of nux vomica, and so on; and when a patient comes in we give him a solution, or mixture A or B, finally forgetting what A or B contains, until finally in practice we get to be routine prescribers.

Now, while we have looked at this matter from the standpoint of one who wishes that we should find out the causes of failure in order that we may improve our practice, it might be well to see how far therapeutics should go. We are always told that surgery is making great advances, and that medicine is standing still. We are also told that "if all the drugs were cast into the sea it would be better for mankind and worse for the fishes," and that the practice of medicine, "the administration of drugs, consists of putting drugs of which we know little into bodies of which we know less." The popular opinion is that we administer a lot of drugs, the patient gets well, we sit down and wonder why, or we administer others and he dies, and we wonder why he died. They point out the unerring accuracy of surgery, and as medical men we receive a certain amount of discredit. Well, does surgery ever cure? What is cure? Cure is *restitutio ad integrum*, the part restored to its normal condition. Surgery is practically, in many cases, subtraction. Does it

ever cure anything? Of course not. Can anything cure in its integrity when it subtracts something?

If you analyze the word cure, surgery never cures. It is a contradiction of terms to say that surgery ever absolutely cures. A patient has an abscess, he goes to a surgeon who makes an incision, and it heals. Is that patient cured? Not at all. So long as that patient lives there is a fibrous induration, there may be interference with nerve supply, there may be circulatory disturbance; the patient has a scar; the patient is never, in the strict sense of the term, cured. In the surgical sense cure has become very much restricted. We see at the present time in the surgical sense cure is restricted to those patients who survive the operation.

As therapeutists, we can certainly do better than that. You remember the other day I demonstrated to you a patient who had stated that after an operation for appendicitis he was discharged as cured. You remember I demonstrated to you the appendix which was left behind, easily felt behind the abdominal walls. You remember I demonstrated that this man was a victim of post-operative adhesive peritonitis, that the small intestines were glued together in one mass. And then when we went on to investigate the case a little further we found the man was a lithemic of about five years' standing, and the operation which he underwent was of no use, but, on the contrary, was a positive detriment.

That is a case put down by the surgeon as cured, which means that the patient got away from the hospital alive. He undoubtedly will figure in the statistics of this operator, a gentleman who is not connected with this hospital, as cured. It would have been better for the man if he had never submitted to the operation. Surgery, which consists in subtraction, can never effect *restitutio ad integrum*. In medicine we can achieve certain results. In some cases we can achieve almost mathematical results. We know how much of a drug we want to give to accomplish certain purposes, and, perhaps, one of our sources of failure is that we are accustomed to be guided by the doses set down in the books. Professor Dana has, undoubtedly, told you that in some cases of specific myelitis the necessary amount of sodium iodid must be enormous. But we have been so talked about for giving large doses that we have gone to the other extreme, and sometimes I am of the opinion that we have emasculated our treatment. To avoid failure you should regulate your force—your dose—in accordance with that which you wish to accomplish.

In the first place, the cure of these conditions must be brought about by better teaching. Materia medica should be taught entirely apart from therapeutics, that is, the materials with which we fight disease should be taught aside from the use which we make of them. In the second year, after a student has learned medical terminology, has mastered his chemistry, anatomy and physiology, he should be put to laboratory work, and handle the drugs themselves, in the crude and in the prepared state, until he knows the drugs as the surgeon knows surgical, obstetric and gynecologic instruments—what they are and what they are used for. I presume there is not one physician out of ten who can tell the difference between magnesium sulphate and zinc sulphate. I presume there is not one out of ten who can be sure he has a bottle of tincture of digitalis before him—knows what it tastes or smells like, as the patient usually makes the discovery. He should learn the medicines, the tools with which he works, as thoroughly as the surgeon learns his.

After the student knows what he is working with, he should be taught therapeutics in his third year, given an opportunity for laboratory drug experimentation, and be obliged to attend recitations. In his fourth year the professor of therapeutics should show him the practical application of drugs in the wards of a hospital and in ambulant clinic. Finally, he should be required to prescribe for patients under the direction of a competent instructor. That would require a great deal of hard work, a great deal of serious work, but it would result in the men going out as well equipped in medicine as in surgery, and would put an end to the spectacle of men from the best medical schools who cannot obtain 30 to 35 per cent. out of a possible 100, on a therapeutic examina-

tion. Then, so far as pharmacy goes, we should not look to wonderful chemical and pharmaceutic combinations, but we should rely, so far as we can, on single drugs and preparations which represent the active principles of crude drugs, pure and reliable preparations.

The number of therapeutists in this country can be almost counted on the fingers. Why? Because it requires a man of broad learning, wide reading, analytical processes of mind, who seeks to get only where the logical deduction from his premises will carry him. He is not only judge, but counsel for both sides of the case, and jury besides; and there are comparatively few men with a mental equipment that enables them to carefully and systematically arrive at a just verdict. Such a man was Tully, such a man was the late George B. Wood, one of the greatest therapeutists this country ever produced. The difficulty is that it is so easy to be led astray, to get into careless ways, to prescribe for symptoms that present themselves instead of getting at the pathologic basis of the condition, and then treating the patient as well as the disease. We are forced also to enter into a more rigid analysis of results.

If therapeutics is backward, it is backward because chemistry and physiology are backward. We have to wait for chemistry and physiology to catch up with us. I will give just one instance. In 1888 Professor Rusby, when he returned to this country from South America, brought me some bark which he collected in Bolivia. All he knew about it was, that the natives told him that the bark would purge, and that it was an emetic. I procured some of it, had it powdered, and found that it produced local irritation of the mucous membrane of the nose. I predicted, in 1889, that the bark probably contained a resin, because when I had extracted all I could by tincture, water precipitated a substance that I found to be distinctly purgative; and, further, I found that the syrup made from the filtrate was more expectorant than the tincture or fluid extract. I then suggested that it might contain an alkaloid possessing expectorant properties. In 1892, Professor Coblentz isolated two resins. In 1893, Professor Eccles found the alkaloid which he named Rusbyine. Thus I waited from 1889 to 1892, before chemistry caught up—before I could prove what I suggested about the chemical and physiologic properties of the bark, now known as cocillaña.

A more striking example of therapeutics, based upon mere empiricism, is that of quinine. In 1640, the Countess d'El Cinchon had a powder which cured chills and fever. In 1649 it came into France as Jesuits' Bark. The tree from which this remedy as a powder was obtained, was described in 1738 by La Condamine. In 1820, quinine was isolated by Pelletier and Caventon. In 1865, Chevalier found that quinine inhibited the development of infusoria. In 1880, Laveran described the malarial parasite. Thus we come to the scientific use of quinine. It appears in the urine after subcutaneous injection, in from thirteen to fifteen minutes. (Binz, Kerner, Lepidi-Chioti). Its elimination is one-third to one-half in six hours, three-quarters in twelve hours (Thau), and total elimination is in forty-eight hours (Kerner).

Osler, a few years later, found the segmenting organism of malarial fever during the chill, and Councilman found that fifteen to twenty-five grains of quinine caused the disappearance of the segmenting organism. So we have the development of the exact, scientific treatment of malarial fever, 250 years after the empirical fact was known that the administration of a certain bark stopped chills and fever.

Now, if we are tardy in our work, we are tardy because chemistry and physiology have not caught up to us, and I venture to say that many of the drugs we now use empirically with success, within the next few years will rest upon a good chemical and physiologic basis.

Materia medica is not an attractive study, nor the attempt to find sense in a mass of nonsense which has been and is being written an easy one. It is not a trifling matter to write a text-book and make it in all respects represent the subject of drug medication to-day. But if each one of us will be more accurate in his diagnosis, will try and get at the physical conditions which underlie the symptoms, using drugs to accomplish certain definite purposes, and will go on

and study his cases, being careful to avoid falling into routine prescribing, or using mixtures that are a disgrace to chemistry and scientific medicine, will regulate his dose according to what is to be accomplished, no matter what the text-books say, and will contribute his mite to the advancement of therapeutic education, then we will have the subject developed, in a much shorter time than seems likely now, and put in its proper place, and we will find medicine where it ought to be, far in advance of the so-called specialties.

"IMPERATIVE IDEA" OR "HOMICIDAL IMPULSE" IN A NEURASTHENIC WITHOUT HEREDITARY TAINT.*

MORTON PRINCE, M.D.,† BOSTON.

Mental obsessions, in persons otherwise sane, are well known to alienists, but I think the general practitioner, who is less familiar with this psychosis, will find the following case of interest, not only in itself, but as throwing an insight into the mental condition of criminals who have committed homicides without apparent motive. When some horrible murder has been committed under the influence of an obsession it is necessarily often not possible to learn from the accused the motive, or, perhaps more correctly, the antecedent psychical state which leads to the act; but by a study of milder forms of homicidal impulse which have been successfully resisted, we can learn to understand the meaning of the severer forms.

It is difficult for laymen to realize that a momentary irresitsible homicidal impulse may suddenly arise in an otherwise sane person, without warning, out of a clear sky, without motive and even against the afflicted individual's, inclinations and feelings, and then cease for the time being, leaving the person in a mentally normal condition until another paroxysm occurs.[1] But to the alienist this is A B C knowledge. This fact is illustrated by the following case:

Miss A. B., forty-two years old; dressmaker. With the exception of some sort of dizzy spells, which will be mentioned later, she always enjoyed good, robust health up to last May. At that time she was subjected to considerable anxiety and mental strain at the time of the confinement of her sister, whose life was considered in danger. She helped hold her sister while being etherized and during the instrumental delivery. She seems to think this ordeal affected her health, for after this, her head felt hot and tired, and she felt generally tired all the time. This neurasthenic condition continued without other symptoms until July, when she gave up work and her present psychosis developed.

She has had a general supervision and care of the child since its birth. Her psychosis consists, or has consisted, for she is much better at present, of an *overwhelming fear* that she would kill the child, and an *impulse* to do this. Against this impulse she is obliged to use self-control and resistance. The way this comes on is interesting and instructive. The fear and impulse are not continuous, but come on paroxysmally without warning, at unexpected moments. When asked to give an example, she said, in substance, of the last attack: "I was walking across the entry when I suddenly felt a queer feeling, which is not a pain, in my head, here and here and here" (indicating the occipital, frontal and parietal regions). This feeling she describes as a "sudden stoppage," as if she "couldn't think any further." With this feeling comes, of a sudden, the fear (that she will kill the child) and the impulse to *do*. As will appear she has other impulses besides the homicidal one.

Besides the pain in the head she has

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*Boston Medical and Surgical Reporter.

†Clinical Instructor in Nervous Diseases, Harvard Medical School.

1 "One of them (the medical experts) doubted whether homicidal mania so-called is a recognized disease." Editorial in *Boston Transcript*, on the Bram trial, January 4, 1897.

had a pain in the left side which has preceded or accompanied the fear and impulse, but is present at other times. These organic feelings seem to constitute a sort of aura.

This attack is of very short duration. It may be only momentary, and I should judge never lasts more than a few minutes. Sometimes she has even awakened at night out of a sound sleep with this fear. The intensity of the fear and impulse may be judged from the fact that she has never been willing to be left alone in the house with the baby (she objected to her sister coming to see me, as that would require her staying alone at home to look after the child,) and that on her first visit she was very much alarmed at her condition, thought she was "going crazy," and was troubled and mortified that she should have such thoughts. Still, she has never doubted that she could control the impulse, but the fear has been a cause of great mental discomfort. She has always insisted that she would not yield to the impulse notwithstanding the effort required to control it. The thought that she should have such feelings has been very distressing, so that she dislikes to talk about them.

The mode in which she was to kill the child has taken different forms, apparently according to the surrounding circumstances. Sometimes the impulse has been to kill it with a knife; at other times, when looking out of a high window, to throw it out; and again to throw it upon rocks and stones when these have been obtrusive by the wayside.

The homicidal fear, which arose in connection with a particular child, was afterwards associated with other children. When, for example, she made a visit, largely for her health, to a relative in a neighboring State, she found that she suffered from the same feelings when she was with this relative's children. She has never had the fear of killing herself or grown people.

In seeking for the origin of this fear, the first exciting suggestion of the mental state, it would seem that it might with considerable probability be found in the following circumstance, if the patient's memory is to be trusted: She has had the responsibility of the care of the baby. One day, while carrying it, she stubbed her toe and nearly fell. At once a fear rushed through her mind of the terrible consequences that might have ensued if she had fallen and killed the baby. The thought of this aroused its associated fear. From this time the fear that she might harm it, with the awful consequences, arose in her mind. Later this fear took definite shape or concrete form, in connection with definite modes of killing. The impulse would seem to be secondary to and a psychological consequence of the fear.

There remains to be mentioned another symptom, which I have purposely not mentioned, because although on first thought an important one, yet I conceive that in this case it is merely an accidental symptom and not an integral part of the psychosis. This is *hallucinations of sight* which arise at the time of the attacks of homicidal fear and impulse. The hallucinations vary according to the form which the impulse takes. When the impulse is to kill with a knife, she *sees* knives and blood about her; when the idea is to throw the child on stones, she sees stones. At one time she saw "brains and blood" constantly. These hallucinations have been very vivid and prominent.

As hallucinations are not an element in this psychosis as ordinarily met with, at first sight it might appear that we had to do with some one of the delusional insanities, but on inquiry I was able to find a simple explanation of these hallucinations, of which the following would seem to be the mode of genesis. This patient has always had the power of visualization to an extreme degree. She says she has always had the power of seeing as a vivid image anything she chooses by thinking intently of it. She illustrates this in my presence, on my asking her to think of her breakfast table[2] as it appeared that morning. She says she sees as vividly as in a dream or as an hallucination the table, the things on the table and the faces of the persons around it.[3]

According to her statement, whenever her mind is occupied strongly with an

[2] It will be remembered that Galton showed that this power of visualization was possessed by people in varying degree. In some people it is normally highly developed, as in this patient.

[3] It is interesting to note that the visual image was more vivid when her eyes were open than when shut.

idea of an object, she is apt to have a vivid visual image of that object. A constant panorama of objects has thus, especially since her illness, passed before her. She makes light of the images not connected with her impulses as being merely the consequences of a faculty which she has always possessed, but the homicidal images have troubled her. These, I take it, are nothing more or less than samples of this visualizing power, and awakened by the particular fear present, so that she sees as hallucinations or visual images the objects concerned with her fear. There have been no hallucinations of the other senses, nor any tendency to internal questionings, and doubts,[1] which last are frequently associated with fears and impulses. Beside this homicidal impulse this patient has exhibited others; for example, to throw anything that happens to be in her hand when the attack comes on; to rush out of a street-car and to jump off a bridge.

During the past week (January 4th to 11th), she has been constantly annoyed by coprolalia, that is, an impulse to use profane language. This impulse seems to be confined to a repetition of the oath, "God-damn." This comes into her mind without external cause, and as she says is quite as likely to arise while she is saying her prayers as at any other time. It distresses her because she says she has never sworn in her life, and she "is not that kind of a person." She has resisted this impulse in that she does not say the words aloud, but they come into her mind all the time. She has occasionally since the onset of the psychosis had this impulse.

In character, unless I am mistaken, this patient is the last person who would by nature have such homicidal or profane ideas. She is fond of children, and children are fond of her. Her moral nature is strong, and her disposition is naturally kindly and amiable. A large part of her suffering comes from the consciousness that she has such horrid feelings so foreign to her disposition. She is proud of her will-power and refuses to allow herself to be governed by an idea.

When her trouble was explained to her, so far as this was possible, she exclaimed that, if that was the case, she would overcome these morbid feelings by her own will-power, and would not be beaten by her "imagination," and she would do this without treatment. (For this reason it is difficult to keep her under observation.) To overcome the fear of jumping off the bridge, she deliberately walked to the open draw and stood there while it was open. This she says cured that fear. She has frequently, when the fear of homicide was upon her, deliberately taken up the child and fondled it to overcome the feeling. At other times, I think especially at the beginning of the psychosis, the impulse has been too strong for this, and she admits having to use great self-control to restrain herself.

No evidences of hereditary taint are discoverable. Her father is said to have died of phthisis when she was fifteen years old. She is proud of the fact that all the members of her mother's and father's family were strong, sturdy characters, and insists that no member of either branch ever had any nervous disease, or was addicted to excesses; but I have no reliable information further back than the immediately preceding generation. She has five brothers and three sisters, all strong and well.

Patient is well developed and nourished, and muscularly strong. The only physical abnormalities discoverable are an internal strabisbus of left eye dating from childhood, old choroiditis of the same eye, absence of lobes to the ears. These can scarcely be regarded as degenerative stigmata.

She is at present moderately "neurasthenic," that is to say, suffers from various sensory disturbances, "nervousness" and exhaustion. Talking about herself brings on the two last, so that she objects to being interrogated. She exhibits also a sort of impulsive lack of self-restraint difficult to describe, but which gives the impression that she resents and is irritated by being questioned, but she denies this, excusing herself by saying that the examination makes her feel worse. With the exception of having frequently suffered in the past from pain in her head, she was perfectly well up to three years ago, when for three weeks

[1] Mickle has called attention to the three D's—Doubts, Dreads (fears), Deeds (impulses), as the three factors in this psychosis.

she had dizzy spells. In these she used to fall down and be very sick at her stomach; at the same time she had an intense painful desire to micturate. No auditory or other symptoms. These attacks would last not over one hour. Recovered perfectly. Only change in herself since has been that she cries more easily over what she reads or hears, and she is not so ambitious; otherwise she was perfectly well up to onset of present illness last May.

The patient has shown marked improvement under treatment (mental therapeutics, electricity and forced feeding).

SOCIETY REPORTS.

SECTION ON OPHTHALMOLOGY, COLLEGE OF PHYSICIANS OF PHILADELPHIA.

Meeting of the Section on Ophthalmology of the College of Physicians, November 17, 1896.
DR. J. M. DA COSTA in the chair.

Unilateral Albuminuric Retinitis,

with a case, by G. E. DE SCHWEINITZ, M.D.
(See page 268.)

DISCUSSION.

DR. J. M. DA COSTA.—Have there been microscopic examinations in cases of this character? This question is suggested because it is uncommon to have one kidney alone affected.

DR. DE SCHWEINITZ.—So far as I am aware, but one post-mortem is recorded, namely, Yvert's case. The right kidney alone, in a state of parenchymatous nephritis, was present, but although Yvert is a French military surgeon and reports with characteristic exactness, if my memory serves me correctly, there was no microscopic examination, but only a description of the coarse pathologic anatomy of the specimen. Cheatham is often credited with an autopsy, especially in foreign abstracts, but his report contains clinical data only, and the autopsy referred to in his paper is the French case just described.

DR. WILLIAM F. NORRIS.—I should like Dr. Da Costa's opinion as to why one kidney, any more than one eye, should be the sole sufferer.

DR. DA COSTA.—I suppose if I were to theorize, I should explain it through the action of the sympathetic nerve, and assume it to be for the same reason that there is flush in pneumonia on that side of the cheek corresponding to the side of the affected lung. This is a very common clinical observation and is the only analogy that occurs to me. I know of nothing from actual observation that bears on this point.

DR. G. ORAM RING made a

Report of the Successful Removal of a Piece of Steel from the Vitreous by the Hirschberg Magnet,

and exhibition of the patient.
(See page 268.)

DR. M. W. ZIMMERMAN spoke of a

Case of Foreign Body in the Vitreous,

with exhibition of patient.
(See page 267.)

DISCUSSION.

DR. G. C. HARLAN had the opportunity of following a case in which a piece of gun-cap had been imbedded in the retina for three years, without causing irritation.

DR. CHARLES H. THOMAS.—Several years ago, I had under my care a group of cases of gun-cap injuries of the eye. In all, on account of rapid degeneration and threatening sympathetic ophthalmia, I was obliged to enucleate, although in two cases the foreign body had been carried for periods of eighteen and twenty-two years, respectively.

DR. S. D. RISLEY asked the President if he recalled to mind the eye enucleated at the University Hospital some years ago, where a foreign body was found sticking in the end of the optic nerve, the presence of which had not been suspected.

DR. B. A. RANDALL spoke of another case in which the foreign body had remained quiescent for a long time. He believes that such results are due to encapsulation of the foreign substance. There was an interesting case which he drew for Dr. Norris at the University Hospital some ten years ago, as he may remember, where the bright piece of gun-cap was visible at the lower margin of the pupil, suspended in the remains of the lens capsule, and giving rise to little irritation; whence it was successfully removed by operation.

DR. NORRIS.—I recollect very well the two cases that have been mentioned; the piece of metal which I extracted from the anterior chamber was a movable one; the patient could throw the foreign body from the anterior to the posterior chamber at will. I have no doubt the ultimate trouble was due to mechanical irritation as well as to the fact that the foreign body was copper. If I recollect aright, the man had some sight in the eye, although greatly impaired.

It has always seemed to me that the reaction from these materials depended, first, on their

asepsis at the time they entered the eye, and, secondly, on their state of comminution.

All the Fellows are probably aware of Leber's ingenious experiments on this subject; he was very careful to introduce aseptic material, but the metals which he chose for this purpose were always in the finest state of pulverization, so that they were in the most favorable condition to be acted on by fluids of the eye. The copper and lead were promptly acted on and caused inflammatory reaction in the vitreous and retina; while the so-called "noble metals," gold and silver, in a similar state of pulverization, produced the same effects to a less degree.

On the other hand, there are quite a number of cases where metallic foreign bodies have remained in the eye for a very long time without injurious results. Jäger has related a case where he watched for years a foreign body in the vitreous, which was apparently absolutely harmless so long as it remained encapsuled, and when it subsequently, some years later, sank in the vitreous, it commenced to make trouble. Of course, if there is a good layer of fibrin around one of these foreign bodies, there is less chance for chemical action and corrosion by the fluids of the eye and for absorption of metallic salts.

DR. HOWARD F. HANSELL.—I would like to refer to a case that is still under treatment. One year ago, the patient applied at the Jefferson College Hospital, and we determined the presence of a piece of steel in the eye. The inflammatory symptoms, however, subsided, and since he lived in Philadelphia and was easily accessible, we adopted the expectant treatment. The vision was lost and the eye gradually atrophied.

This year he came back with opaque lens, discolored iris, atrophic eye and a great deal of pain; he asked that something should be done for it. He was sent to the Polyclinic Hospital for examination by the Rœntgen ray process, not so much to determine whether a foreign body was there, but to learn whether the rays would show the shadow. Dr. Stern, with a great deal of patience and skill, was able to get a beautiful skiagraph showing the presence of the foreign body. We endeavored to remove the steel by means of a magnet, but were unsuccessful. I then enucleated the eye and found a piece of steel three-eighths of an inch long, caught in the ciliary body.

In answer to a question of Dr. Oliver, Dr. Hansell explained the method adopted by Dr. Stern, as follows: The plate was made fast against the man's temple, then by means of a lead funnel the rays were directed toward the inner angle of the eye of the other side, and passing through the nasal bones, the outline of the outer angle of the orbit was distinctly shown. The steel was in the ciliary region and cast a well-defined shadow, while the eye itself was dimly outlined.

I may say, in this connection, that my friend, Dr. Clark, in Columbus, has made some successful experiments with this process, and has been able to determine the presence of a foreign body posterior to the iris by thrusting a very narrow plate covered with rubber up the nostrils.

DR. HANSELL read a paper upon

Report of the Successful Removal of a Piece of Steel by the Hirschberg Magnet.

and exhibited the patient

(See page 267.)

DR. CHARLES A. OLIVER presented a brief

Clinical and Histologic Study of a Case of Epithelioma of the Corneo-scleral Junction.

(See page 267).

DR. OLIVER also exhibited a series of

Ophthalmoscopic Pictures of Peculiar and Rare Chorio-Retinal Changes, the Result of Traumatism.

The first of this grouping was seen but a few hours after the patient, a man of forty-two years of age, had been struck in the left eye by a fist. Almost total blindness ensued immediately after the accident.

The eyeball was unruptured. The cornea seemed unusually brilliant. The anterior chamber was deepened, especially in its peripheral portion. The pupil was round, and the iris, though tremulous, was mobile to consensual reaction. The lens was dislocated directly back, its superior border resting against the retina just behind the inferior portion of the equator of the globe. The vitreous humor contained some rather fixed, doubtful streaks of blood in its anterior portion.

As shown in a water-color sketch made by Miss Washington, the optic disc was greenish in tint and appeared bloodless. There were a few deeply-situated hemorrhages in the retina, and a series of large choroidal ones extending along the retinal vessels, which were reduced to mere threads. There were broad and greenish elevated areas, as though the deeper retinal tissues against the choroid were thickened, swollen, and opaque. The patient became blind in a few minutes and never regained vision.

In contrast with this sketch, which illustrated the grossest effects as seen ophthalmoscopically from concussion accidents, Dr. Oliver exhibited water-color drawings of five other cases extending from minor degrees of visible change to the more pronounced varieties, one of which (the fourth example) closely resembled the chromo-lithograph in Jonathan Hutchinson, Jr.'s, well-known case.

DISCUSSION.

DR. HARLAN thought that in order to explain the blindness in Dr. Oliver's first case, there must have been injury to the retro-bulbar portion of the optic nerve resulting from a fracture of the orbit. In this Dr. Oliver coincided, believing that this was proved by the

bloodless condition of the optic-nerve head and the greatly-marked reduction of the main retinal trunks.

DR. S. D. RISLEY—Some years ago I reported to this Section the history of a case to which my attention was called while absent on my summer vacation. A man had been thrown from a hay-rake, and was struck in the temple fossa by one of the teeth, which penetrated the soft tissues deeply and probably caused a fracture of the orbital plate. I found advanced atrophy of the optic nerve, marked infiltration of the tissues surrounding it, and large white patches in the macula and throughout the temporal half of the eye-ground, apparently the site of extensive hemorrhages, as remnants of the clots were still visible. In this case there had probably been a post-ocular hemorrhage following a temporary exophthalmos.

DR. B. A. RANDALL.—A case that I reported to the American Ophthalmological Society ten or twelve years ago had a little peculiarity which may have a bearing upon some of the peculiar appearances of the eye-ground. There was, as the result of traumatism, rupture near the disc, especially interesting and peculiar in that it passed up on the temporal side of the disc to its upper margin and then was lost in a rounded area to the nasal side that looked as if it had been subjected to torsion. The result was an inflammatory lesion leading to complete atrophy.

DR. EDWARD JACKSON presented a case of

Deficiency of Pigment, Allowing the Fundus Reflex to Show through the Iris.

(See page 269.)

H. F. HANSELL, *Clerk of Section*

LIBRARY TABLE.

AN AUTUMN SINGER. By George M. Gould, A.M., M.D. Rough cloth; pp. 163. Philadelphia: J. B. Lippincott Company.

It is not often that the medical reviewer is blessed with an oasis such as this little volume of charming verse. There is much in some of the sonnets to touch the heart, much that appeals to the higher sense, and here and there a sentiment that seems to reveal the author as he is in *cor cordis*. Whoever knows Dr. Gould, knows that nothing small or unworthy has room in his many-sided nature, but yet not all would credit him with the fire and tenderness these poems seem to show. There is true poetry in the sonnet

The soul is like the man in visored steel
Whose face, by strange, mysterious decree,
He dare reveal to none; none live and see.
The body is the masque whose folds conceal,
More absolute than iron's locked anneal,
Soul-prisoner hid within. Whate'er the plea,
Self's secret deep is kept more utterly
Than it were doom of death should we reveal.

And hence our piteous, awful loneliness!
Alone we live and die, and cannot tell
The truth, although the secret kill; unshown
Soul's face to dearest friend! More merciless,
Fate makes us mysteries to ourselves—in cell
Of flesh unknown of all, by self unknown!

In a lighter vein, yet instinct with beauty, are the lines to "June" (p. 64). Another gem (p. 59) is entitled "Life," and the opening verse of the volume is the true poet theory of evolution. We congratulate the talented author on the volume, and trust that it will not be long ere we are again favored with another.

AUTOSCOPY OF THE LARYNX AND THE TRACHEA. (Direct examination without a mirror.) By Alfred Kirstein, M.D., Berlin. Authorized translation (altered, enlarged and revised by the author) made by Max Thorner, A.M., M.D., Cincinnati, O. Cloth; crown 8vo.; pp. 68. Price, 75c. Philadelphia: F. A. Davis Company.

This translation, made at the request of the author, is in reality a second edition of the original German monograph, an abstract being appended, bringing the description of this method up to date. It is an astonishingly simple manner of laying the air passages open to inspection, and time will prove that the necessity of everyone who desires to master the intricacies of laryngology to familiarize himself with the details of this technic. A point of particular merit is that there is no padding in the article, which appears in the most concise form.

THE THEORY AND PRACTICE OF COUNTER-IRRITATION. By H. Cameron Gillies, M.D. Cloth; pp. 236. Price, $1.50 net. New York and London: MacMillan & Co.

In this valuable contribution to medical literature, the history of counter-irritation is traced from its inception, with a view to obtaining a clearer understanding of a very important branch of medical treatment. What-

ever criticisms are made, and necessarily there are some, are in a spirit of fairness, and the references are ample, though not too full. The volume is divided into two parts, the first being devoted to a critical and historical review of all allied facts, and the second merely dealing with the practical aspects of the matter as presented to the profession at the present day. This portion is especially valuable, presenting in concise manner much that, already appearing in works of medicine, is yet so diffused as to be difficult to obtain in available form.

HIGH ALTITUDES FOR CONSUMPTIVES. Principles or guides for a better selection or classification of consumptives amenable to high altitude treatment, and to the selection of patients who may be more successfully treated in the environment to which they were accustomed previous to their illness. By A. Edgar Tussey, M.D., Adjunct Professor of Diseases of the Chest in the Philadelphia Polyclinic. Cloth; pp. 144. Price, $1.50. Philadelphia: P. Blakiston, Son & Co.

The title of this little volume is a sufficient indication of its intents and scope, and no more remains for the reviewer than to say that it fully carries out its purpose. The press-work is fine, the size of the book convenient and the style of diction practical. There is no doubt that it will serve in some measure to lessen the number of victims of the "dread white plague," since it opens up certain lines of thought not generally considered by the profession.

DIAGNOSIS AND TREATMENT OF DISEASES OF THE RECTUM, ANUS AND CONTIGUOUS TEXTURES. Designed for practitioners and students. By S. G. Gant, M.D., Professor of Diseases of the Rectum and Anus, Women's Medical College and University Medical College of Kansas City, Mo., etc., with chapters on "Cancer" and "Colotomy" by Herbert William Allingham, F.R.C.S., Eng. Cloth; pp. 399. Price, $3.50 net. The F. A. Davis Company, Philadelphia.

The classification of this volume is such that the reader can at once refer to what he wants without reading half the book, a point of no little value to the busy man, and when to this is added the fact that when he turns to the subject he desires, he is apt to find all that he wants without the necessity of referring to other authorities, one reason will at once be seen for the popularity the book has so quickly attained. It contains everything up to date of interest to those who wish to do rectal work, and two chapters, those on "Railroading as an Etiological Factor in Rectal Diseases" and "Auto-Intoxication or Auto-Infection from the Intestinal Canal" are entirely new in a work of this kind. The press-work and illustrations are of a very high degree of excellence.

TABLE TALK is still easily holding its own as a distinctive home magazine, the general excellence of the articles and their applicability to the every-day uses of life, giving it a place that so far has not been successfully filled by any literary rival. The February issue is fully up to the standard and is an unusually good number.

LIPPINCOTT'S latest issue has a romantic story of lost treasure recovered from the sea, in which two Andalusian maids, a wily priest, a gallant sailor and a modern ghost figure very entertainingly. There is no falling-off in the excellence of the main portion of the magazine, in which there are several very interesting articles.

What better magazine can be desired than SCRIBNER'S? The fact of an article appearing in its pages gives to it a cachet of literary value much appreciated by the writer, if one may judge from the names of those who contribute regularly, since it is an assured fact that no author whose reputation is made will risk it by writing for inferior publications. The number for February is exceptionally bright, the articles having and showing a wide range, although possessing practically equal merit.

FOR RINGWORM OF THE SCALP:

℞

Chrysarobin	5 parts
Salicyl. acid	2 "
Ichthyol	5 "
Vaseline	88 "

M. ft. ung.

Sig.: Rub in twice daily.

This must be persisted in for several weeks, then followed by

℞

Powdered zinc oxide	6 parts
Precipitated sulphur	4 "
Silicated earth	2 "
Benzoated lard	28 "

M. ft. ungt.—DR. WOLFF, of Atlanta in *New York Medical Record.*

PERISCOPE.

FORMULÆ.

FOR BRONCHITIS:

℞

Ac. benzoic	gr. ix
Tannin	gr. ivss

M. et div. in chts. No. XL.
Sig.: Four to be taken daily.

FOR MIGRAINE:

The *Presse Médicale* gives this formula:

℞

Antipyrine	7½ grains
Phenacetine	1½ grain
Acetanilide	¾ of a grain

M. For one cachet. The caution is added that it will be prudent not to take more than three cachets in twenty-four hours at first.—*N. Y. Med. Jour.*

FOR MYALGIA:

To be used with massage.

℞

Tinct. belladonnæ	℥j
Tinct. aconiti,	
Tinct. opii	āā ℥ij
Liniment. saponis	q. s. ad ℥vj

M. Sig.: Poison. To be used externally only.
—DR. HARE in *Dunglison's C. & C. Record.*

FOR SENILE CYSTITIS:

℞

Fld. ext. hydrang	℥ij
Tr. gent. comp	℥iv
Tr. staphisagris,	
Tr. cannab. ind	āā ℥i
Syr. aurant cort	q. s. ad ℥iv

M. S.; A teaspoonful three times daily.—HOPKINS in *The Medical Fortnightly.*

NEWS AND MISCELLANY.

A special meeting of the Buffalo Academy of Medicine was held February 16th, with special reference to pernicious legislation at Albany. At the meeting of the Section on Pathology there was carried out this program: "Cultivation of Gonococci and Exhibition of Culture," Dr. F. S. Busch; "The Workings of the Bureau of Animal Industry at East Buffalo," N. P. Hinckly, D.V. M.

There is no remedy so promptly curative in gonorrhea in the female as ichthyol, according to Canova, in *Centralblatt für Gyn.* He uses injections of 0.5 per cent. in water with the most satisfactory results. It causes no pain, reduces the inflammation by the first injection, and often the patient is wholly recovered in six days.

Health Officer Weaver, of Norristown, states that the odor of formaline, the new disinfectant, is a "combination of bilge water and the emanations from a sauerkraut kettle." He adds, somewhat superfluously, that no germ will survive it.—*Philadelphia Record.*

The officers of the Berks County Medical Society, for the year 1897, are as follows: President, Dr. M. A. Rhoads; first vice-president, Dr. C. W. Bachman; second vice-president, Dr. Israel Cleaver; recording secretary, Dr. James W. Keiser; corresponding secretary, Dr. George W. Kehl; treasurer, Dr. A. S. Raudenbush.

The regular meeting of the Medical Section of the Buffalo Academy of Medicine was held February 9th. Program: "Should the Marriage Contract be Limited by Law?" Dr. E. T. Rulison; "Protective Inoculations in Typhoid Fever and Cholera, and the Role of Sero-therapy in Tetanus, Tuberculosis, Streptococcus Infections and Syphilis," Dr. Frank J. Thornbury.

A case of belladonna poisoning, resulting from use of an ointment, is reported in the *Montreal Medical Journal* by Dr. Campbell. The patient had been confined several days previously and was being treated with a view of getting rid of her milk by an ointment containing extract of belladonna. She had a slight rash over all the body, which had the appearance of measles and somewhat cresceutic in character. An acute rash is somewhat difficult to decide as to its character, but the history of the use of belladonna decided this. The temperature was a little over 101° and the pulse was exaggerated. He also mentions several cases of belladonna poisoning from the use of liniments.

The Payment of Doctors' Bills.—Our contemporary *Truth* has done a good turn to the medical profession in drawing attention to the dilatoriness and neglect with which the bills of medical practitioners are paid by their patients. The editor says, "There seems to be a sort of idea that a doctor's fees are not a legal debt, and that it is quite a favor to pay them any time within a year or two of the date of the attendance for which they are charged. This is an entire delusion, and it puts many a struggling practitioner to great inconvenience and loss, and, what is more I believe it drives not a few into the toils of the advertising money-lender." In proof somewhat of the way persons delay paying their medical man mention may be made of some figures furnished by "The British Medical Protection Society." This Society, among other duties, undertakes

the collection of over-due fees and accounts of its members. During the past five years application for the overdue fees of the members have been made, amounting in all to a sum of no less than £46,376 12s. 6d. Of this amount £25,870 5s. 6d. was collected without the necessity of resorting to legal compulsion. But even the first named immense sum cannot represent probably more than a proportional part of the unpaid indebtedness of the public to the medical profession, for it is hardly to be supposed that each member of the profession, to whom is owing fees which he cannot obtain, is a member of the British Medical Protection Society.—*The Med. Press and Circ.*

It is reported that the Shah of Persia has selected as his family physician Dr. William S. Vanneman, a graduate of the University of Pennsylvania in 1888, and formerly a resident physician in the Philadelphia Hospital.—*Med. Fortnightly.*

The value of the immediate use of hot water after enucleation of the eye-ball—Recognizing the utility of hot water as a hemostatic in surgical and obstetric cases, Simeon Snell (*Ophthalmic Review*, Vol. xv., No. 180, p. 283) was led to adopt its use for the same purpose following enucleation of the eye-ball and with the utmost success. The method employed has been as follows: Immediately after the conclusion of the operation and whilst the patient is under the influence of the anesthetic, the parts are dried as much as possible with a pledget of cotton wool, and then a roll of cotton wool, which has been dipped in very hot water, is immediately plunged into the socket. Bleeding will often be arrested at once, but, if necessary, the proceeding may be repeated, and then, if the bleeding has not entirely ceased, it will generally amount to no more than a little oozing. The usual pad and bandage may be applied with the eye practically dry. Not only does the hot water act as a hemostatic, but recovery is promoted and the socket is healed some days earlier than would have been the case if the hot water had not been applied.

Pneumopexy. **Bayer** (*Centralblatt für Chirurgie*, January 16, 1897, p. 37) reports a case of sarcoma of the right thoracic wall in a child thirteen years old, in which the collapse of the lung and the attendant symptoms that followed the opening of the pleural cavity were corrected by attaching the lung to the costal parietes. The neoplasm arose from the eighth rib on the right side, and after being exposed it became necessary to resect the rib above and that below. Finally the affected rib was divided at its cartilaginous junction and blunt dissection of the mass begun. In the separation of some adhesions the pleural cavity was opened in several places. Signs of general collapse appearing, one of the openings was hastily sutured and the other packed with gauze and only a portion of the tumor removed. When the operation was renewed three days later the pleural cavity was again opened and symptoms of collapse appeared. Through the opening the lower margin of the upper lobe of the lung was brought out and attached with three sutures to the periosteum of the adjacent sixth rib. The patient at once showed signs of improvement, the upper lobe alternately expanding and collapsing, while the lower lobe remained collapsed. The latter was not attached to the margins of the remaining opening, in order that free drainage might not be interfered with. The result was in every way satisfactory. For a time there was some dyspnea, but this diminished as the lower lobe of the right lung resumed its function.

Inebriety in America is one of the greatest sources of peril to civilization and progress. It is very pronounced as a disease, and can be often traced in waves and currents where the causes are unknown.

All efforts to remedy inebriety by moral means have failed; although applied with great fidelity and enthusiasm, and ample means, yet inebriety has notably increased. The present labors of both men and societies along the moral side of this subject are evidently nothing but agitations, whose real value is simply to call attention to the evil.

Inebriety, when studied from the side of science, even in the most superficial way, appears as a great physical disorder following a line of law that may be seen and understood, the practical application of which promises the most satisfactory results.

Inebriate asylums, as stations where the inebriate can be housed and studied, are necessary means for the cure and restoraiion of the inebriate, along the line of natural laws; and their practical volue is assured beyond all controversy and doubt.

Inebriety in America, as elsewhere, must be studied above all theories and dogmas, before it can be known or understood. The inebriate is no exception to the vast armies of defective and degenerate, who appear everywhere as the result of violated law and physical conditions of life and surroundings.—T. D. CROTHERS, M.D., in *Moody's Mag. of Med.*

The best preventative measures for pertussis are generally considered to be isolation, thorough purification of raiment and other articles upon which rest a suspicion of infection, and the thorough use of disinfectants; and we are not without proof that favorable results have depended on the persistency and thoroughness attending the application of these measures, says *Pediatrics.*

If prevention can be applied to a disease after it has found its victim, it must be to abate its virulence, and the best measures are cleanliness, pure air, good light, destruction of sputa, excreta, etc. These methods must recommend themselves to the judgment of

every physician as they are remedial as well as prophylactic in germ disease. Here, as with the well, there must be thoroughness and an unyielding enforcement of these measures.

Those who nurse the sick should avail themselves of all the helps cited, avoiding so far as possible contact with the diseased, and the inhalation of their breath, and be diligent in the purification of their surroundings. It being a conceded fact that the germs of this disease are carried in clothing and other articles which have been exposed, contact with such articles should be rigidly avoided.

Josias, in his new work, "Thérapeutique Infantile," recommends the use of thymol instead of carbolic acid as a spray in this disease. A vessel containing the following solution is placed over a small night-lamp in the room and allowed to evaporate:

℞

Thymol	10	(℥ij s)
Alcohol	300	(℥jxs)
Acquæ	700	(℥xvj)

At the Trousseau Hospital an alcoholic solution of thymol and menthol is used several times a day for spraying the rooms set apart for whooping-cough cases. A vapor-atomizer and the following formula are employed:

℞

Thymol	6	(℥jss)
Alcohol at 96°	120	(℥iv)
Menthol	6	(℥jss)

M. Sig.: 'Tablespoonful in the atomizer which has been previously filled with water.

Unpleasant and sometimes serious complications follow unskilful attempts to remove foreign substances from the external auditory canal, and Preotraschensky (*Glasgow Med. Jour.*) offers the following suggestions:

1. An unskilled person should never attempt the instrumental extraction of a foreign body.

2. Foreign bodies reach the middle ear almost solely as the result of clumsy attempts at removal.

3. The foreign body usually does less harm to the ear than its extraction by an unpracticed hand.

4. The changes produced by the presence of a foreign body in the ear cannot be estimated by the length of time during which it has remained there.

5. The injection of warm water is an infallible (?) means of securing the evacuation of any foreign body from the ear; irrigation with alcohol may be further necessary to prevent swelling of the intruder.

6. There is no indication to expedite the removal of foreign bodies which are giving rise to no troublesome symptoms.

7. In inflammatory processes caused by necrosis from unskilled attempts at extraction, expectant treatment suffices so long as no dangerous symptoms are present. Turpentine and ether for larvæ; these oils cause inflammatory conditions, so we had better resort to instrumental means. (When the foreign element proves to be of the vegetable kingdom, water would better be omitted from the methods suggested, as such a substance readily absorbs moisture, and so increases in size, making its extraction even more difficult than before).

List of Presidents of the American Medical Association.—The following list of names, taken from the *Journal of the American Medical Association*, represents the presidents of the Association from its beginning to the present time:

Dr. Jonathan Knight (President of the convention.

Dr. Nathaniel Chapman.....1847-48
Dr. Alexander H. Stevens.....1848-49
Dr. John C. Warren.....1849-50
Dr. Reuben D. Mussey.....1850-51
Dr. James Moultrie.....1851-52
Dr. Beverly R. Wellford.....1852-53
Dr. Jonathan Knight.....1853-54
Dr. Charles A. Pope.....1854-55
Dr. George B. Wood.....1855-56
Dr. Zina Pitcher.....1856-57
Dr. Paul F. Eve.....1897-59
Dr. Harvey Lindsley.....1858-59
Dr. Henry Miller.....1859-60
Dr. Eli Ives.....1860-63
Dr. Alden March.....1863-64
Dr. Nathan S. Davis.....1864
Dr. Nathan S. Davis (held over).....1865
Dr. D. Humphreys Storer.....1866
Dr. Henry F. Askew.....1867
Dr. Samuel D. Gross.....1868
Dr. William O. Baldwin.....1869
Dr. George Mendenhall.....1870
Dr. Alfred Stille.....1871
Dr. D. W. Yandell.....1872
Dr. Thomas M. Logan.....1873
Dr. Joseph M. Toner.....1874
Dr. W. K. Bowlin.....1875
Dr. J. Marion Sims.....1876
Dr. Henry I. Bowditch.....1877
Dr. T. G. Richardson.....1878
Dr. Theophilus Parvin.....1879
Dr. Lewis A. Sayre.....1880
Dr. John T. Hogden.....1881
Dr. J. J. Woodward.....1882
Dr. John L. Atlee.....1883
Dr. Austin Flint.....1884
Dr. Henry F. Campbell.....1885
Dr. William Brodie.....1886
Dr. E. H. Gregory.....1887
Dr. A. Y. P. Garnett.....1888
Dr. W. W. Dawson.....1889
Dr. E. M. Moore.....1890
Dr. William T. Briggs.....1891
Dr. Henry O. Marcy.....1892
Dr. Hunter McGuire.....1893
Dr. James F. Hibberd.....1894
Dr. Donald Maclean.....1895
Dr. R. Beverly Cole.....1896
Dr. Nicholas Senn.....1897